



Ohio Department of Rehabilitation and Correction

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Gary C. Mohr, Director

TO: Barry Goodrich, Warden
Lake Erie Correctional Institution

FROM: Jayne Haverfield, Prison Audit Administrator
Bureau of Internal Audits and Standards Compliance

SUBJECT: 2012 Full Internal Management Audit Report

DATE: September 25, 2012

I am enclosing a copy of the Internal Management Audit Report for the Lake Erie Correctional Institution following your full internal management audit on September 18-20, 2012. There were a total of forty-seven (47) standards found in non-compliance during the audit which will require a plan of action from your institution unless you wish to appeal any of the non-compliance findings.

During a final review of the audit standards found in non-compliance, there was one ACA Non-mandatory standard and one Ohio Standard that were reviewed as compliant. This has changed your audit scores slightly for those two areas.

Responses to non-compliance should be forwarded to this office on the approved format located on the BIASC intranet site and must be received no later than October 9, 2012. Following the receipt of the plans of action, the documents will be discussed with the appropriate Deputy Director/designee, if necessary, and Michelle Burrows, South Region Prison Audit Administrator will conduct a reinspection. You will be notified in advance of the reinspection review.

I appreciate the support and cooperation of you and your staff during the audit. If you have any questions regarding this report, please feel free to contact this office.

CC: Gary Mohr, Director
Stephen Huffman, Assistant Director
Linda Janes, Chief of Staff
Ed Voorhies, Region Director, Office of Prisons
Annette Chambers, Office of Administration
Kelly Sanders, Office of Administration
Andrew Albright, Chief, Bureau of Internal Audits and Standards Compliance
Michelle Burrows, Prison Audit Administrator, BIASC

OHIO DEPARTMENT OF REHABILITATION AND CORRECTION
Lake Erie Correctional Institution
Conneaut, Ohio
September 18-20, 2012
Full Internal Management Audit

Audit Chairperson – Jayne Haverfield, Prison Audit Administrator

- I. General Administration, Physical Plant – Safety – Personnel – Employee Safety
Steve Olds – Safety and Health Coordinator Brian Smith – Safety and Health Coordinator
Correction Reception Center Ross Correctional Institution
- Leon Hill – Labor Relations Officer Dan Lipperman – Assistant HCA (Sept. 18)
London Correctional Institution Belmont Correctional Institution
- II. Security and Operations
Barb King – Deputy Warden Robert Morgan - Captain Joe Dina - Lieutenant
Lorain Correctional Institution Marion Correctional Institution Ohio State Penitentiary
- III. Fiscal, Food Service, Information Technology, Correctional Industries
Kathy Cole – Administrative Assistant
Belmont Correctional Institution
- Pam Callahan – External Auditor (Ohio Standard Chapter 14)
Office of Administration
- IV. Inmate Programs & Special Services
Laura Solnick – Unit Management Administrator Kent Litzenberger – Principal
Lorain Correctional Institution Belmont Correctional Institution
- Martha Jerew – Victim Coordinator
Office of Victim Services
- V. Medical & Mental Health Services
Michelle Viets – Regional Nurse Administrator Carol Smith – Quality Improvement Coordinator
Bureau of Medical Services Ohio State Penitentiary
- Robyn Schaffer – Northern Psychology Director
Bureau of Mental Health Services
- VI. Training
Jennifer Clemans — MAS1 (Sept. 19)
Corrections Training Academy
- VII. Inmate Rights/Grievances
Don Coble – Assistant Inspector (Sept. 19)
Chief Inspector’s Office

A. INTRODUCTION

The Full Internal Management Audit of the Lake Erie Correctional Institution was conducted on September 18-20, 2012. Jayne Haverfield, BIASC Audit Administrator served as the chairperson of the audit and coordinated all audit issues through Andrew Albright, BIASC Chief. Lake Erie Correctional Institution will be scheduled for an initial accreditation audit prior to February 28, 2013. This review of operations serves as the annual internal audit of the facility, including all ACA and Ohio Standards, since the previous annual audit.

During this audit, an annual sanitation inspection of the entire facility and an annual safety inspection of all OPI and Career Technical Education areas were conducted by an independent and qualified person. The completed inspection forms are sent to the facility as a supplement to this report.

B. EXAMINATION OF RECORDS

The team evaluated compliance levels with audit standards by reviewing both the prepared accreditation files and observing institution operations throughout the facility. It should be noted that the audit team considered all indicators of performance when determining compliance, including that represented within the audit documentation and overall observations of institution procedures and practices. The audit team did, however, focus on facility operations in the past year in determining compliance with audit requirements.

1. Accreditation File Preparation

The accreditation files were found in mixed condition. The Accreditation Contact, Ms. Bowser, stated that although timeframes were set for staff to provide documentation for the files, the deadlines were not adhered to by several departments. The files did not contain signed auditor compliance checklists to illustrate they had been completed or reviewed by anyone at LAECI. The rules and discipline and special management files were also especially difficult to review as they did not follow DRC policy or DRC forms usage.

Despite these issues, many file sections were found to be in overall good shape, i.e. human resources, training, education, library, inspector, and mental health. Several of the food service files were found with no documentation provided. The medical files were well constructed, however the incorporation of CCA policy did create some confusion. The department heads need to review their own files and understand the documentation contained in them so that future auditors do not have such a difficult time with some of the sections.

ACA standard 4-4003-1 was not reviewed during this audit as it is a new standard. The facility will need to have this file constructed and prepared for their upcoming ACA audit.

2. Significant Incidents/Outcome Measures

The Significant Incident Summary Report (SIS) and the Health Care Outcome Measures Report (OM) were reviewed by the audit chair. Both reports are attached at the end of this report.

In comparing the SIS from DOTS with the SIS provided by the facility, the following are contradictory:

- For offender on offender assaults, DOTS SIS shows 9 in July where the facility report shows 4.
- Offender on Staff assaults from the DOTS SIS shows 13 occurred in August where the facility report shows 12.

The Outcome Measures report needs to be reviewed and checked for the following:

- Number 1A(10) should reflect direct admissions only. This number should not include any emergency trips that resulted in an admission. This also creates double-reporting from number 1A(11).
- Numbers 1A(13) and 1A(14) need to reflect the numbers specified by BOMS in the report sent from Jennifer Clayton in March to the Health Care Administrator.
- Number 4A(1) does not show that any problems identified by the quality assurance process have been corrected.

3. Status of Previous Non-Compliant Standards

This is the first internal management audit conducted at the Lake Erie Correctional Institution under the management of Corrections Corporation of America. Therefore there are no previous non-compliance issues to address.

4. Previous ACA Reaccreditation Audit

a. Status of Approved Plan of Actions for Noncompliant Standards

The facility has not yet been accredited under the management of CCA so there is no prior ACA report.

b. Status of Any Negative Issues/Observations/Concerns

The facility has not yet been accredited under the management of CCA so there is no prior ACA report.

C. COMPLIANCE LEVELS

The institution achieved a compliance level of 94.7% among the **ACA mandatory standards for Adult Correctional Institutions**. Of the sixty-one mandatory standards, three (3) were found in non-compliance, four (4) were judged to be non-applicable to the operation of this institution, and the remaining fifty-four (54) standards were all found in compliance.

The institution achieved a compliance level of 94.4% among the **ACA non-mandatory standards for Adult Correctional Institutions**. Twenty-four (24) of the non-mandatory standards were found in non-

compliance during the internal audit and an additional thirty-five (35) of the standards were judged to be non-applicable to the operation of this institution.

The institution achieved a compliance level of 66.7 % with the **Ohio Standards**. A total of twenty (20) of the Ohio standards were found in non-compliance, and an additional eighteen (18) of the Ohio standards was judged to be non-applicable. A total of 68 Ohio standards were reviewed during the internal audit.

D. AUDIT TEAM RECOMMENDATIONS/OBSERVATIONS

Based on the overall inspection of the facility and the review of the audit files, the audit team would like to offer the following recommendations to the institution:

Conditions of Confinement/Quality of Life:

1. The institution staff needs to conduct a complete and thorough facility inspection of every area, closet, storage room, mechanical room etc. throughout the facility to ensure all areas are clean, neat, organized, and free from clutter, hazards, and/or any policy violations.
2. Staff was very professional, friendly, and helpful during the audit. Inmates were dressed appropriately and found to be wearing their identification badges. The inmate atmosphere appeared mostly calm. Outside grounds were clean. Buildings appeared in good repair, with some exceptions noted in subsequent sections of the report.
3. It was apparent throughout certain departments that DRC policy and procedure is not being followed. Staff was interviewed and some stated they are not sure what to do because of the confusion between CCA policy and DRC policy. Some staff expressed safety concerns due to low staffing numbers and not having enough coverage. Other staff stated that there is increased confusion due to all the staffing transitions.
4. Fire Safety Concerns:
 - Fire doors are not kept unobstructed and operable. In the Building and Maintenance Trades area, the crash gate (501-C) opens into the path of egress and is padlocked with a dead bolt lock. There are no exit signs. In the Evergreen Industries area, crash gates have been added at doors 539/512C/512B that are padlocked and opening into the path of egress.
 - The fire alarm panel had 2 trouble lights in central control.
 - Hydraulic closures were removed from doors 207/208. Several other hydraulic doors were held open with other items.
 - In segregation, a power strip was the primary power for a microwave/refrigerator/and coffee pot. Also there were no written procedures for evacuation, and employees were unfamiliar with their keys. There were no food temp logs.
 - In the food service area, a large plastic trash bag was tied to an oven door. The oven had been used and the door was left open to cool down. This was a potential fire hazard.
 - Of twelve staff interviewed, none knew which key opened the fire box. This key needs to be the same for all fire boxes and all staff need to be familiar with this key.
5. Monthly inspections are being conducted by the Safety and Health Coordinator; however the inspections could be more thorough by enforcing more consistency with the DRC Chemical Control

policy, sanitation, and maintenance issues. This effort could facilitate an improvement with compliance issues relating to 4-4212M and 4-4329M.

6. Weekly inspections are being conducted of all food service areas; however many areas are being repetitively documented as not in compliance with issues such as daily food production temperatures, incorrect dish temperatures, no paper towels or soap at hand washing stations, and incorrect cooler/freezer storage temperatures. (Relates to 4-4324M)
7. Security Concerns:
 - During the audit, one auditor observed that one officer left his post for 10-15 minutes (Huron C/D) and did not let his partner know that he left or where he was going.
 - Several staff is not knowledgeable of the key notching of egress keys and need to be provided further training. (Relates to 4-4195M)
 - The PIM's did not contain all the required information however the facility corrected this during the audit.
 - Log books do not show shift checks of equipment or chemicals as required by applicable DRC policy.
 - Tool Control was very good overall. Most vaults required minimal engraving or color coding corrections. Officer Witt demonstrated great knowledge in DRC policy and procedure with Key, Lock and Tool Control. A few recommendations include that supervisors need to be consistently reviewing and signing the Daily/Weekly Tool Report Forms. Staff are also not documenting properly with "closed" instead of a slash mark if the area is not open during a shift. A copy of the broken tool report needs to remain in the vault until corrected.
 - Less than lethal munitions: The pepper ball system (two pepper ball guns) in central control had an outdated inventory and was stored loaded and unsecured. The pepper ball guns are also being issued by non-certified personnel, but are carried by certified personnel. The facility needs to post a memo of who is authorized/certified to utilize the pepper ball guns and when these are to be utilized as staff is currently allowed to carry it loaded as a show of force, especially during chow.
 - Key and Lock Control: Not all egress keys that are issued were notched.
 - Contraband: Minor contraband is being held in Officer desk drawers. Officers indicated that items are brought up to the vault weekly. The minor/major contraband vault was clean but very full. Initial logging and accountability in the vault checked ok; however they were unable to show proof or authorization for contraband that was destroyed. Dispositions were not being logged on the form.
 - Not all paperwork is up to date in Central Control. No emergency dedicated phone line is available. The phone system does not have any type of "off hook alarm". Central Control, Maintenance, Sallyport Control, and Perimeter vehicles use non-MARCS radio systems as well as MARCS. The auditors recommend one radio system be used if possible. The key/door/lock reference book is incomplete: it does list the key ring, the ring count and the key number, but the locations are not listed. Only the locksmith has access to the computer program which contains the key/lock reference. Security auditors recommended that a read-only format is provided in Central Control on the computer for officers there.
 - Post orders are not in DRC compliance or format – i.e. the language between CCA and ODRC needs to reflect ODRC and be written on the DRC form.

8. Rules and Discipline Concerns:

Overall the accreditation files appeared good (15 out of 23) in the Rules and Discipline section. However the practice does not follow DRC policy and required timeframes. The RIB system as a whole needs to be reviewed to ensure future compliance with the required DRC processes.

- Conduct reports are not being heard at the Hearing Officer level and information is not being entered into DOTS. One Sergeant informed the auditors that the conduct reports are provided to the Hearing Officers and are not returned with disposition or entered into DOTS. The partial log for August was reviewed (seven pages with 46 conduct reports per page), and all tickets were expired with no dispositions.
- From the DRC DOTS report it was found that there were 229 total open cases going back to May. In August, it shows that there were 78 open hearing cases, 52 closed cases (4 by disposition and 4 referred to RIB with no hearing conducted, and 44 cases with no action and expired).
- The ADO Report from May reports that 182 tickets were written in one week. DOTS does not reflect these numbers; another demonstration of reports not being entered into DOTS.

9. Segregation Observations:

- Ranges were clean, however recreation cages were dirty, and not all cages have exercise equipment.
- There were inmate complaints of no laundry, linen, or cell cleaning being provided and this could not be disproved.
- There were no laundry schedules or structure available to staff.
- Supervisor rounds were observed but they were not addressing or resolving any inmate concerns or issues.
- Officers were not observed talking to inmates when making rounds.
- About half of the DRC 4118's reviewed were incomplete.
- There is no stock of jumpsuits, blankets, or sheets on hand. The quartermaster stated to the auditor that they do not supply them to segregation, however segregation stated that the quartermaster does supply them.
- All segregation cell shower windows were found to be covered with some sort of paper. Most segregation cells were found to have blankets, clothes, etc. hanging on makeshift clotheslines to cover sight into the cells. Many cells had posters, magazine pages or pictures hanging on the walls. (Relate to 4-4140). Many of the clotheslines were removed after the second day of the audit.
- Overall the documentation pertaining to special management privileges provided for the accreditation files was very poor. Segregation Unit Individual Record Sheet (DRC 4118's) were not being consistently utilized prior to the audit week. Most individual records for inmates in segregation did not document meal times, health care daily visits, linen exchange, clothing exchange, cell cleaning or barber. This was also the case for any 4118/4117's found during the audit.
- There were questions raised whether inmates are able to shower in segregation. Showers are only turned on for 30 minutes in the evening, and with 3 inmates per cell it was questioned whether there is adequate shower time.
- Segregation logs do not reflect phone calls being made available to inmates per DRC policy and comments reflected by the inmates in segregation. When staff were asked to explain the process, it was explained differently in talking to SMU staff and unit staff. Both areas reflected that the other area was responsible for the phone calls.

- The eye wash station in segregation was empty.
 - A urine specimen was found sitting on the officers desk in segregation control. When questioned about this, the officers stated it was there when they arrived for shift. There was no label on the specimen.
10. The inmate orientation checklist was not consistently being signed by staff prior to the audit week. Practice needs to be monitored to ensure staff are completing the forms properly and timely.
11. Unit Management concerns:
- One case manager is doing a good job of entering information into the system. However there has been a big staff turnover and only one staff person is ORAS trained.
 - Staff need to be trained to complete the PIT within 90 days.
 - It is also recommended to contact the Office of Victim Services to request programs training for PROVE and Victim Awareness.
 - Also, the mission statements need to be posted in the units.
 - Unit Manager Pfifer has maintained excellent records of his unit meetings and town hall meetings.
12. The workplace violence liaison needs to be appointed, and trained by OVS. Victim Coordinator needs to attend the last/next quarterly Victim Coordinator meeting/training on November 17, 2012.
13. The facility has a local written policy and procedure to address spill containment and clean-up procedures for infectious waste, but do not have a specific cleaning team. All employees have been trained to handle and manage infectious waste spills.
14. Medical:
- Pill call was observed and it was found that there is no officer is in the area where pills are dispensed.
 - The use of the chart review form found in the charts does not comply with the policy that governs sick call.
 - The refrigerator needed for medication in the pill should not be used for nutritional substances also. There should be a separate refrigerator used for nutritional substances.
 - The last peer review found for Dr. Tran (Mental Health) was conducted in 2010. The 2012 peer review needs to be added to the ACA Mandatory file for peer review.
 - The mental health auditor also noted that with segregation so crowded, it is time intensive for staff to conduct watches and rounds.
 - The consult process needs to be rebuilt as it appears broken due to staff attempting to follow 2 systems – DRC and CCA. The process currently in place does not allow staff to backtrack to find what has gone wrong.
 - Staff seem unsafe. There are lots of inmates in medical but no correctional officers around medical.
 - The mental health department is functioning well overall but has challenges of complying with two policies for the same procedure (CCA and DRC). It is recommended that staff vacancies be filled as soon as a determination is made as to what discipline is needed.
15. Some inmates interviewed indicated to the auditors that they felt unsafe. Some inmates stated they felt that staff had “their hands tied” and had little control over some situations.

16. Food Service concerns:

- The food service manager does not appear to understand the basics required by the food service ACA standards.
- The DRC cycle menu had not been in place but was begun the week of the audit. This menu needs to be continued and utilized daily per DRC Policy. Prior to this, LAECI did not have approval from DRC to use their own cycle menu.
- All DRC food service forms need to be utilized daily.
- Temperatures of food products were not regularly taken. Food serving temperatures were not taken one day of the audit because “we were too busy” as reported from a food service coordinator.
- Sanitization of the pots and pans was not being completed in accordance with approved methods. It is recommended to run the pots and pans through the dish machine to sanitize them.
- On the third day of the audit, it was found that dish temps were recorded prior to the machine being used.
- Inmate food service workers are not issued any extra clothes but are issued an apron which they have to launder themselves.
- Due to the lack of documentation in several food service accreditation files, and the files being returned multiple times when the auditor gave the opportunity to fix them, it was found to be a very high probability that the documentation was being falsified. This was not proven however the facility needs to be aware of this issue to monitor to ensure it is not occurring.
- Items in dry storage were stored up against the walls instead of 4” from the wall as required for proper air circulation.
- A locking mechanism was on the dry storage door allowing someone to be locked inside the room.
- There were no safety guards on the meat slicers and inmates were using them.
- Inmate workers in food service were found eating on the line and in the kitchen.
- A review of the inmate feeding line operation is recommended as the current inmate feeding line takes several hours and this could possibly be improved.

17. Sanitation and Safety concerns:

- Several water fountains in units were inoperable and found with standing water and debris in them.
- Heat producing appliances were not plugged directly into the wall in several areas (microwaves, refrigerators, coffee pots). This is not compliant with Ohio Fire Code.
- Emergency Breathing Apparatus’s (EBA’s) were hard to find and had not been inspected. Many were found locked inside file cabinets or behind items in storage closets.
- Most all ceiling fans and vents were found to be dirty.
- Huron C/D: The entrance was clean. Inmate bedding areas were clean. Beds that were empty had no mattress and some were missing springs and wires. Some beds were now rendered unusable due to these items missing. The rest of the unit was found in poor sanitation. Water fountains were backed up and inoperable. Showers had black spots/mildew issues. Ceiling fans dirty. Door 114-B had a device holding open the door.
- Ontario C/D housing unit had dust/dirt in corners, on window sills, and on fans. Walls in the dayrooms and entry were dirty from 2 feet down to the floor. Showers had black spots/mildew issues. Inmate bedding areas were clean.

- Superior A/B was found in poor sanitation. The sink microwave area was very poorly kept.
- Ontario A/B ceiling fans were dirty. Bathroom vents were totally obstructed with dirt and the smoke detector was in alarm mode in the bathroom. Black spots/mildew on the ceiling. The dog room had a blocked egress. The inmate barber was cutting hair using his own personal equipment.
- Recreation was very busy but found in poor sanitation. A vending machine was partially blocking an exit.

18. In reviewing chemical control procedures, the H&S Auditor recommended that the bulk usage of chemicals being used in areas be eliminated. One of the goals of chemical control and having a chemical control room is to keep bulk storage of cleaning chemicals located in 1 area. At Lake Erie Correctional 5 gallon containers are sent to areas allowing inmates to refill bottles as necessary. In the chemical boxes there are limited amounts of bottles in each chemical box making it necessary to refill the bottles several times before the chemical boxes are replenished. This methodology is much more difficult for staff to track accountability and it also promotes more waste/usage than necessary. Considering the poor level of sanitation in housing units at LaECI it appears that either cleaning is very limited or a lot of cleaning chemicals are being misused and or wasted. On a positive note, the medical and dental areas were found to be following excellent chemical control accountability procedures.

19. Inmates housed in segregation complained about the hours that recreation is offered. Many complained that it was offered late in the evening between 11:00 PM and 12:30 AM and the DRC 4118's observed showed this was the practice for those inmates, with no indication that security or safety concerns dictated otherwise. This is a quality of confinement concern that could be improved and perhaps lessen inmate agitation within the unit.

E. OHIO FACILITY OBSERVATION PERFORMANCE

OBS 02-03 Intrasystem Transfer. The Intra-system Receiving process shall be uniform in order to facilitate continuity of care during the Receiving Process. Completion of DRC 5255 Intra-system Transfer and Receiving Health Screening form shall be completed in its entirety; however, completion of this form does not substitute for a comprehensive assessment, file review, and appropriate documentation on the part of the receiving institution.

The auditors found the following concerns: required patient demographic fields at the bottom are not filled out in their entirety; all significant diagnoses/operations/invasive procedures for the patient are not reflected on the problem list; and not all entries on the problem list have dates to indicate when they were added to the problem list.

OBS 02-05 Medication Administration. The purpose of the Medication Administration protocol is to provide guidelines for the safe administration of medication in compliance with all legal and nursing standards.

The auditor found that there were blanks on the refrigerator temperature log, and that there is no officer present during pill call. Oral cavity checks are not performed by a correctional officer after medication administration to each inmate.

OBS 02-07 Infirmary Care. The purpose of the Infirmary Services protocol is to provide an enhanced level of care to those patients who have a need for an increased level of health care services, but are not ill enough to require hospitalization or intensive nursing services. Patients admitted to the infirmary shall be a high priority and shall receive complete and thorough daily quality medical and nursing care.

It was found that patients are not seen timely. Nursing assessments were not completed minimally every 8 hours and documented on DRC 5396. A distinct discharge note was written by the ALP upon discharge, and ALP progress notes are not always completed for every day the ALP is on site.

OBS 02-08 Telephone Triage. The purpose of the Nursing Telephone Triage protocol is to outline the process utilized for telephone triage of urgent, emergent, and non-urgent health services requests. Telephone triage of inmate patient medical concerns represents a fundamental component of access to healthcare services.

There are not always progress note entries corresponding to the log entry. Documentation in the progress note by the nurse who receives the call does not always include information received and any other appropriate medication documentation or actions taken by the nurse.

OBS 02-09 Nurses Sick Call. The purpose of this standard is to evaluate the Nurse Sick Call (NSC) process as the primary access for an inmate to access healthcare services. Timely and appropriate NSC assessments are critical in providing quality health care to our patients, as well as ensuring the quality of nursing triage and care provided is appropriate to the complaint.

The Health Services request form DRC 5373 is not being triaged and signed off by the RN. Inmates requesting to be seen are not always scheduled for sick call within 48 hours following the receipt of the health services request, or immediately if indicated. The auditor found that medical staff are using a chart review form which is not a DRC form for this process. Nurses sick call is not conducted daily in special management housing areas (segregation). DRC 4118, Individual Segregation sheets were missing signatures in segregation and segregation medical overflow.

OBS 02-10 Doctors Sick Call. Doctors' Sick Call (DSC) serves as the primary mechanism patients are seen and evaluated by Advanced Level Providers (ALP). ALPs see patients in sick call for acute care issues, referral from NSC, post hospitalization follow-up, routine medical care, post-emergency visits, and specialty consultation reviews.

The auditor found that patients' doctor appointments were often delayed. Again the use of a chart review form is being used which is not in DRC policy. Patient education was found to be lacking often. Follow-ups are often not found to take place. Problem lists are not updated as required.

OBS 02-11 Diabetes CCC. Treatment for offenders with diabetes should be provided in a standardized manner that is consistent with nationally recognized disease treatment guidelines and has the goal of improving patient outcomes while reducing morbidity and mortality.

It was found that the type of diabetes is not always indicated on the problem list; The patients are not

always referred to the dietician for lifestyle/dist management. Immunizations against influenza and pneumonia are not always provided or refused.

OBS 02-13 HIV CCC. The purpose of the HIV chronic care protocol is to provide coordinated follow-up and treatment to all patients diagnosed with HIV disease.

From a review of 5 medical records for inmates in HIV chronic care clinic it was found that compliance was not being monitored for two patients who are on antiretroviral therapy.

OBS 02-14 Emergency Services. Rapid emergency care is critical in decreasing mortality and morbidity. Emergent assessment and intervention by nursing and medical staff will improve the outcomes of patients in acute distress. Emergency service reviews all aspects of the emergent event from initial event to follow up care at the institution.

The order for emergency transport does not always include the method of transportation (van vs. squad). There was no mention of a follow-up appointment or needs indicated at the post emergency trip doctors sick call visit.

OBS 02-15 Hospitalizations. Patient's admitted to the hospital or FMC shall be evaluated by medical and nursing staff upon return to the parent institution. The patient's treatment plan shall be updated to include care related to this hospitalization. A complete and thorough review of the hospitalization documents is essential to initiate or augment the institutional treatment plan.

From two patient files reviewed, one file did not show that the discharge medical summary was reviewed and signed/dated by the ALP, and did not show that follow-up specialty consultation recommendations were ordered or if there was documentation of the rationale for not ordering it.

OBS 02-17 Dental Pain. The purpose of this protocol is to clarify the process medical and nursing staff follows to screen inmates for dental emergencies, both on arrival at the institution and on a day-to-day basis. Early identification and referral is important to alleviate pain and ensure appropriate care.

It was found that a complete set of vital signs was not recorded with the nurse's assessment. The patient's weight was not taken or recorded.

F. EXIT DISCUSSION

The final exit interview was held at 5:00 PM on Thursday September 20, 2012 in the Warden's Conference Room with Warden Goodrich and Assistant Warden Vantell in attendance. The audit chairperson reviewed the compliance levels with staff in attendance. The chairperson also explained the procedures that would follow the audit for the reinspection visit.

Each auditor reviewed his or her portion of the audit standards and offered general observations during individual close outs to the staff members in attendance. One of the two Assistant Wardens participated in each these closeouts, with the Warden attending when he was available to attend.

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.

Adult Correctional Institutions ACA Mandatory Standards Noncompliance

4-4215 Mandatory. Written policy, procedure and practice govern the control and use of all flammable, toxic and caustic materials.

All areas were examined for chemical inventories and for accuracy and completeness and area supervisors do not have a current, accurate list of hazardous chemicals for their areas as required by DRC policy. Cleaning chemicals not in usage were not secured in many areas. Invisible ink in the sallyport did not have an inventory or MSDS. Several chemical products, including hazardous items, found in the warehouse were without an MSDS, an inventory, or an 1885E. Chemicals in the maintenance chemical room had HMIS stickers with no hazard numbers. The inventory on tank was last done in 2011 for Oxygen/Acetylene/Nitrogen, and the tanks were found mixed together in maintenance. The inmate barber was using H-42 (Barbercide) that was not in a marked container. In the food service area there were no chemical approval forms, with "Mothers Mag Wheel Cleaner" being used on equipment. A gallon of paint was found in the storage closet of Huron A/B and was not inventoried.

4-4222 Mandatory. Written policy, procedure and practice specify the means for the immediate release of inmates from locked areas in case of emergency and provide for a backup system.

The local fire plan is general and does not describe specific steps for staff to take for the means of immediate release of inmates from locked areas in case of emergency or the specific steps for the backup system. Employees interviewed could not demonstrate the following: a knowledge of the local fire plan; a knowledge of the rapid release of inmates from cells in locked areas; or a knowledge of which keys used to activate the alarm system; and many simply stated they had no idea what they should do.

4-4400 Mandatory. When an offender is transferred to segregation, health care personnel will be informed immediately and will provide assessment and review as indicated by the protocols established by the health authority. Unless medical attention is needed more frequently, each offender in segregation receives a daily visit from a health care provider. The visit ensured that offenders have access to the health care system. The presence of a health care provider in segregation is announced and recorded. The frequency of physician visits to segregation units is determined by the health authority.

There was no way to verify that each offender in segregation receives a daily visit from a qualified health care professional. Nurses are not documenting visits on the DRC 4118 Individual Segregation Sheet. It could not be verified that patients are being seen and offered daily health care in segregation.

**Adult Correctional Institutions
ACA Non-Mandatory Standards
Noncompliance**

4-4132 **Revised January 2012. Cells/rooms used for housing inmates shall provide at a minimum, 25 square feet of unencumbered space per occupant. Unencumbered space is usable space that is not encumbered by furnishings or fixtures. At least one dimension of the unencumbered space is no less than seven feet. In determining unencumbered space in the cell or room, the total square footage is obtained and the square footage of fixtures and equipment is subtracted. All fixtures and equipment must be in operational position.**

All housing units provide less than the requirement of 25 square feet of unencumbered space per occupant. These ranged from 21.8 to 23.1 square feet of unencumbered space per occupant.

4-4134 **Each inmate confined to a cell/room for ten or more hours daily is provided a sleeping area with the following: a sleeping surface and mattress at least 12 inches off of the floor; a writing surface and proximate area to sit; storage for personal items; and adequate storage space for clothes and personal belongings.**

Each inmate confined to a cell/room for less than ten hours daily is provided a sleeping area with the following: a sleeping surface and mattress at least 12 inches off of the floor; storage for personal items; and adequate storage space for clothes and personal belongings.

On the first day of the audit, 41 out of 50 cells were housing 3 inmates per cell. On day two of the audit, 12 inmates were transferred out, leaving 29 out of 50 cells housing 3 inmates per cell. Also, the single watch cells were observed to have 2 inmates housed. In the triple bunked cells, the third inmate was sleeping on a mattress on the floor. In one single watch cell, one inmate slept on the bed while another inmate slept on a mattress on the floor. In one other single watch cell, one inmate slept on the bed while another inmate was observed on the floor on a blanket (no mattress).

4-4141 **All cells/rooms in segregation provide a minimum of 80 square feet, of which 35 square feet is unencumbered space.**

Each cell provides 97.75 square feet of total space and 46.25 square feet of unencumbered space for one inmate per cell. On the first day of the audit, 41 out of 50 cells were housing 3 inmates per cell. On day two of the audit, 12 inmates were transferred out, leaving 29 out of 50 cells housing 3 inmates per cell.

4-4183 **Written policy, procedure, and practice require that correctional staff maintain a permanent log and prepare shift reports that record routine information, emergency situations, and unusual incidents.**

In the log books, officers are not reviewing the log books or completing their close out of who is relieving them.

4-4184 **Written policy, procedure, and practice provide that supervisory staff conduct a daily patrol, including holidays and weekends, of all areas occupied by inmates and submit a daily written report to their supervisor. Unoccupied areas are to be inspected weekly.**

Documentation could not be provided to demonstrate weekly rounds in the unoccupied areas due to the weekly unoccupied inspection report not being completed.

4-4185 **Written policy, procedure, and practice require that the warden/superintendent or designee, assistant warden/superintendent(s), and designated department heads visit the institution's living and activity areas at least weekly to encourage informal contact with staff and inmates and to informally observe living and working conditions.**

Documentation could not be provided to show that weekly rounds are being conducted by executive staff.

4-4192 **Revised August 2009. Written policy, procedure, and practice provide for searches of facilities and inmates to control contraband and provide for its disposition. These policies are made available to staff and inmates.**

In segregation during the month of August, documentation reviewed showed that searches were conducted only 16 days out of 31 days for that month. Daily cell searches are required by 310-SEC-01.

4-4200 **Revised January 2008. Written policy, procedure, and practice govern the inventory, issuance and accountability of routine and emergency distributions of security equipment.**

The pepper ball system in central control had an outdated inventory (not conducted monthly as required) and routine issuances by non-certified personnel. Staff are also permitted to carry the pepper ball guns as a show of force, especially during chow. This practice needs to be discontinued immediately and the facility needs to follow permitted usage guidelines DRC policy 310-DRC-49, Pepper Ball System.

4-4207 **Written policy, procedure, and practice provide for the preservation, control, and disposition of all physical evidence obtained in connection with a violation of law and/or institutional regulation. At a minimum, the procedures shall address the following:**

- **chain of custody**
- **evidence handling**
- **location and storage requirements**

Contraband is not being processed daily to the contraband vault and instead being left in desks and unit areas. The contraband vault needs to be organized and items need to be processed timely for proper disposal. Required forms/documentation was not being completed properly on the contraband log for disposal of items.

4-4230 **There are written guidelines for resolving minor inmate infractions, which include a written statement of the rule violated and a hearing and decision within seven days, excluding weekends and holidays, by a person not involved in the rule violation; the inmate may waive their appearance at the hearing.**

Hearing Officers are not reviewing and hearing tickets within the required seven days. The majority of tickets are expiring due to not being heard at the hearing officer level.

- 4-4234** **Written policy, procedure, and practice specify that, when an alleged rule violation is reported, an appropriate investigation is begun within 24 hours of the time the violation is reported and is completed without reasonable delay, unless there are exceptional circumstances for delaying the investigation.**

Documentation for extensions of security control could not be provided.

- 4-4238** **Revised January 2008. Written policy, procedure, and practice provide that inmates charged with rule violations are scheduled for a hearing as soon as practicable but no later than seven days, excluding weekends and holidays, after being charged with a violation. Inmates are notified of the time and place of the hearing at least 24 hours in advance of the hearing.**

Most tickets are not being heard or reviewed within seven days, and are expiring due to not being heard.

- 4-4253** **Written policy, procedure, and practice provide for a review of the status of inmates in administrative segregation and protective custody by the classification committee or other authorized staff group every seven days for the first two months and at least every 30 days thereafter**

Due to not inconsistent utilization of the DRC4118, no documentation could be provided to show seven day reviews for the first two months or 30 day reviews thereafter are being completed.

- 4-4255** **There is a sanctioning schedule for institutional rule violations. Continuous confinement for more than 30 days requires the review and approval of the warden/superintendent. Inmates held in disciplinary detention for periods exceeding 60 days are provided the same program services and privileges as inmates in administrative segregation and protective custody.**

Local Control Hearings are not being consistently conducted. As an example, 8 inmates from prior to August 20 were still waiting for hearings as of September 20, 2012. Although the one piece of documentation in the file was good, there was no documentation found that the practice was being consistently completed.

- 4-4257** **Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuing observation.**

The one piece of documentation in the file was good however the practice is not consistently being done as segregation logbooks were inconsistent with documented rounds/activities. Suicide observation logs are also not consistently being maintained during watches. During the audit, the paperwork for one inmate on constant watch was not updated for one hour from 12:30 PM to 1:30 PM. The officer responded that he catches his paperwork up at one time.

4-4258 **Written policy, procedure, and practice provide that inmates in segregation receive daily visits from the senior correctional supervisor in charge, daily visits from a qualified health care official (unless medical attention is needed more frequently), and visits from members of the program staff upon request.**

Daily visits from medical and the senior correctional supervisor are not being documented in employee log books or on the DRC 4118's. Numerous 4118's during the days of the audit did not show medical making the required rounds in segregation. Also, the employee log book did not show rounds of the correctional supervisor.

4-4263 **Written policy, procedure, and practice provide that inmates in segregation receive laundry, barbering, and hair care services and are issued and exchange clothing, bedding, and linen on the same basis as inmates in the general population. Exceptions are permitted only when found necessary by the senior officer on duty; any exception is recorded in the unit log and justified in writing.**

Inmates in segregation are being not provided laundry exchange as required and the officers could not provide information about how exchange occurs and there was no schedule for clothing exchange. Further, the DRC4117's do not document the process. DRC 4118's and 4117's also did not document any exchanges to negate these findings.

4-4270 **Written policy, procedure, and practice provide that inmates in segregation receive a minimum of one hour of exercise per day outside their cells, five days per week, unless security or safety considerations dictate otherwise.**

Recreation is not always provided 5 times a week in segregation. The practice was reviewed by checking individual documentation. Many records reviewed showed only 3-4 times per week or not being conducted at all.

4-4318 **Revised August 2004. Therapeutic diets are provided as prescribed by appropriate clinicians. A therapeutic diet manual is available in the health services and food services areas for reference and information. Prescriptions for therapeutic diets should be specific and complete, furnished in writing to the food service manager, and rewritten annually, or more often as clinically indicated. (Revised: 12/16/03 Errata)**

The facility has not followed the DRC cycle menu and was using their own diet menu for the special diet. The documentation for the inmate followed in the file did not match his diet required by the doctor or the same timeframe.

4-4320 **Written policy precludes the use of food as a disciplinary measure.**

The facility was unable to provide complete documentation for the file, then added a memo stating that an alternative meal had not been provided during the audit cycle. However in a separate special management file, a meal loaf was shown as being served on June 1, 2012. The facility was not able to provide a DRC 4118 Individual Segregation sheet or show that a meal loaf was served per DRC Policy 60-FSM-05, Alternative Meal Service.

4-4325 **Written policy, procedure, and practice provide that stored shelf goods are maintained at 45 degrees to 80 degrees Fahrenheit; refrigerated foods at 35 degrees to 40 degrees Fahrenheit, and frozen foods at 0 degrees Fahrenheit or below, unless national or state health codes specify otherwise.**

Temperature records that were reviewed showed consistently within compliance however the actual temperatures checked during the audit were not in compliance. On the first and second day of the audit, the auditor observed no temperatures checked when the food was put out onto the line. No staff on the line had thermometers. When meals were served at the segregation satellite area, there were no thermometers and no temperatures taken. Segregation staff interviewed stated that sometimes they checked the temperature however they did not know the proper holding or serving temperatures for food nor did they have any paperwork to write down the temperatures.

4-4328 **Written policy, procedure, and practice require that at least three meals (including two hot meals) are provided at regular meal times during each 24-hour period, with no more than 14 hours between the evening meal and breakfast. Variations may be allowed based on weekend and holiday food service demands provided basic nutritional goals are met.**

Most documentation provided showed that meals were being served more than 14 hours apart between the evening meal and breakfast, especially in segregation.

4-4354-1 **Added August 2006. The management of offenders with Methicillin Resistant Staphylococcus Aureus (MRSA) infection includes requirements identified in the communicable disease and infection control program. In addition, the program for MRSA management shall include procedures for:**

- **evaluating and treating infected inmates in accordance with an approved practice guideline**
- **medical isolation, when indicated**
- **follow-up care, including arrangements with appropriate health care authorities for continuity of care if offenders are relocated prior to the completion of therapy.**

When an inmate with MRSA is being transferred from LAECI to another facility, staff are not using the intrasystem transfer summary to notify the next facility that the patient currently has MRSA and is under treatment and wound care for the disease.

4-4425 **Authorities having jurisdiction are promptly notified of an offender's death. Procedures specify and govern the actions to be taken in the event of the death of an offender.**

The shift commander log did not note the patient's death or notifications regarding the death (occurred at OSU). An incident report was written by an officer indicating that multiple attempts were made to contact the Captain and Captains Office with the information but he received no answer.

Ohio Standards Noncompliance

OH 04-01 All inmates who are placed in segregation from general population, or who are released from segregation to general population housing shall have their personal property accurately inventoried. This inventory shall be documented and a copy shall be retained in the inmate property file.

It was found that each inmate does have a property file but they are either not being completed during the time that housing assignments change or they are not being completed properly or not in the file.

OH 04-02 The Quartermaster shall update and maintain all Inmate Property Files in a secure manner without the use of inmate workers and shall also maintain a written monthly inventory of all clothing items and equipment in storage. The institution Quartermaster will document all state property issuances to inmates on the Inmate Clothing Form (DRC4077-Male/DRC4055-Female).

The quartermaster is not maintaining a monthly inventory of all clothing items and equipment in storage. Also, food service uniforms are not issued or documented on DRC 4077.

OH 05-01 ODRC requires the Managing Officer, Deputy Wardens, and designated department heads to visit the institution's living and activity areas at least weekly to encourage informal contact with staff and inmates and to informally observe living and working conditions. In addition, each institution shall maintain a system of two-way communication between all levels of staff and inmates.

The employee sign-in logs for three random housing units, health care, food service, programming areas, and segregation were reviewed. It was found that rounds are not being made by the Warden, Assistant Warden or department heads, but were being made by the Shift Supervisor and ADO.

OH 05-02 If areas that house inmates on psychotropic medications exceed 90 degrees Fahrenheit, temperatures must be monitored regularly by the correctional officer and logged on a Cell Temperature Log (DRC5292). The following measures will be taken:

- a. Increased ventilation to the area through utilization of fans to improve airflow and reduce room temperature to less than 90 degrees.**
- b. Provision of increased fluids and ice.**
- c. Allowance of additional showers to provide cooling.**

There was no documentation that temperatures were being recorded if/when taken. Temperatures are not documented on DRC 5292, Cell Temperature Log.

OH 06-09 The facility has a written confined space program that was developed by the Health and Safety Coordinator and is made readily available to all staff. The program includes the following elements:

- The facility maintenance supervisor evaluates the workplace to determine the locations of all confined spaces. In the event confined spaces are identified, the maintenance supervisor is responsible for making the determination if a space is permit or non-permit required.
- Where a permit is required, the permit will be initiated by the maintenance supervisor and authorized by the Health and Safety Coordinator.
- The Confined Space Entry Permit, DRC Form 1682 is used to document the procedure
- All permit required confined spaces shall be marked as required by OSHA 1910.146.
- A list of confined spaces and permit required spaces is maintained and updated as each additional space is located.

Procedures are developed for rescue operations in the event of an emergency rescue as required in OSHA 29 CFR 1910.146.

Training is provided to all employees and inmates affected by the confined space program. Training records are maintained by the maintenance supervisor and training officer.

Equipment for confined space entry is provided at no cost to the employee. The supervisor for each employee entering confined spaces shall maintain the equipment properly and ensure it is used properly.

The facility does not have a written confined space program.

OH 06-10 The written local Fire Prevention and Safety Plan shall be reviewed annually and updated as needed.

The plan shall also be reviewed by an independent outside inspector trained in the application of national fire safety codes and be reissued to the local fire jurisdiction upon each revision.

Facilities shall also develop and post written evacuation plans for each building/area of the facility. Evacuation plans shall include building/room floor plans and the use of exit signs and/or directional arrows for traffic flow.

The local Fire Prevention and Safety Plan and facility evacuation plans shall be publicly posted for all interested parties.

The facility's local fire prevention and safety program has not been updated to reflect institution specific direction to be taken by staff during an actual emergency. General information is provided but not a specific plan for staff to follow to direct them in what to actually do.

OH 07-02 **Where the spider alert system is not in place, telephone systems are established with an off hook alarm system to respond to staff emergencies. Where the spider alert system is in place, all staff have in their possession the required spider alert mechanism. For both types of alarms, staff must respond to the alarm and have it visually cleared by a supervisor.**

NOTE: Telephone off-hook alarms cannot be eliminated without the approval of the appropriate Regional Director.

The facility does not have telephone off-hook alarms or any documentation of an approval from the Regional Director.

OH 11-01 **Treatment for offenders with chronic illnesses should be provided in a standardized manner that is consistent with nationally recognized disease treatment guidelines and has the goal of improving patient outcomes while reducing morbidity and mortality.**

Inmates diagnosed with a chronic illness that is not addressed through one of the other established chronic care protocols shall still be enrolled into Chronic Care Clinic. Such conditions may include, but are not limited to: Cancer, Multiple Sclerosis, Parkinson's Disease, Sickle Cell Anemia, Crohn's Disease, and thyroid disorders.

Treatments are not being provided in the required standardized manner as indicated by nursing not consistently following chronic care patients, the Advanced Level Providers not documenting clear treatment plans, and Doctors are not addressing what needs to happen, and patients are not being referred back to the doctor when they refuse treatment.

OH 11-02 **The purpose of this protocol is to establish guidelines for complete, appropriate and timely completion of specialty clinic referrals to FMC, OSUMC, and other specialty clinics; and to facilitate and standardize the continuity of care received by inmates returning from specialty consultation appointments.**

A process needs to be put into place to review ATP's with the patients. There is no documentation of this in the files. Patients must be placed on sick call and a treatment plan discussed.

OH 11-03 **The purpose of this protocol is to define the mechanism by which nursing competency is evaluated for DRC medical nursing staff. All medical nursing staff in DRC shall participate in the nursing competency training and assessment program.**

The Health Care Administrator cannot demonstrate or explain an overall plan and schedule nurse competency testing. Nursing competency evaluations have not been completed. The QIC cannot show documentation of reporting to the CQI committee the number of nursing staff that tested and the overall results by competency, nor can the QIC demonstrate documentation that shows this information was reported back to the nursing staff.

OH 11-04 Each medical CQI program shall develop a system that addresses real or potential problems identified through investigation of complaints and grievances.

Each medical operation shall review the number and types of informal complaints and grievances related to health care to assess for trends and commonalities in conjunction with the Institutional Inspector.

The facility has not yet conducted quarterly ad hoc groups and needs to begin this process to address real or potential problems identified through investigation of complaints and grievances. This needs to be conducted in conjunction with the Institution Inspector.

OH 12-02 OCSS staff properly identifies inmates with special needs and suspected special needs through the referral and red-flagging process, in compliance with Departmental Policy 57-EDU-01, Inmate Assessment and Placement in Educational Programs. The Intervention Assistance Team (IAT) interviews referred and red-flagged inmates.

Of fourteen IAT files reviewed: documentation could not be found to show that all red-flagged or referred inmates were interviewed by the IAT or that the IAT consisted of the appropriate staff. It was found that red flag letters are on grounds, but there was no documentation to show that IAT meetings were held since June 2012.

OH 12-03 OCSS staff properly serves inmates with special needs and suspected special needs through the Evaluation Team Report (ETR) and Individual Education (IEP) Team procedures, in compliance with Departmental Policy 57-EDU-11, Special Education. Proper documentation of the process is appropriately recorded.

The Special Education monthly report is incomplete and information stating completion of meetings is incorrect. There was no documentation of classroom teacher involvement and IEP/ETR's were not signed or completed. Many red flagged students have not started in Special Education. Of the auditor observations sheet: B, C, D, F, and I are not being completed.

OH 14-10 Bank Statement Reconciliation Verification Bank statements for all internal funds shall be accurately reconciled to the appropriate checkbook at the end of each month. All internal funds should be reconciled in the Cashless Commissary and Trust fund Accounting System (CACTAS) bank reconciliation module monthly. At the end of each month, within 10 (ten) days of receiving your bank statement, complete the on-line Monthly report of Cash Book Balances and Bank Reconciliations. Any bank or savings and loan association holding deposits shall be insured by federal insurance agencies.

The facility does not reconcile internal funds in the CACTUS bank reconciliation module monthly. Bank statements for all internal funds are reconciled at CCA headquarters.

OH 15-01 It is mandatory that each institution offer reentry approved programs that clearly address a criminogenic need in one or more of the eight dynamic domains/needs area and offer a variety of non reentry approved programs, groups and activities.

Programs titled Cage Your Rage and Inside Out were the only two programs offered. No other programs or activities are offered in the units.

OH 15-02 The Reentry Coordinator will work to ensure that program providers prioritize admission based upon the static risk assessment, dynamic needs assessment, length of sentence, statutory requirements, and the ability to complete the program before release.

DORAS/RAP waiting lists are not being maintained as a combined waiting list and a check of sign-up sheets indicated that inmates are participating in programming with either no case plans or recommendations.

OH 15-04 The Unit Management Administrator or the responsible Deputy Warden are responsible for monitoring the quality of the Prison Intake Tool (PIT) interview, documentation and management of the Case Plan and Reentry Accountability Plan (RAP) and ensuring all program providers are communicating through the inmate's case plan and RAP screens.

The auditor found that there is no tracking in place for PIT reviews. Many Case Managers and Unit Managers do not have ORAS access or training.

OH 15-05 The parent facility Unit Management Staff will complete a Prison Intake Tool (PIT) within 90 days of arrival at the prison on inmates rated as Moderate, High risk on the Prison Screening Tool (PST) and have one year or more of prison time to serve.

No PIT screening processes were in place, therefore PITs are not being completed as required.

OH 17-01 Unit Management Staff will prepare a packet of information regarding release plans for offenders who are incarcerated in order to ensure that all offenders released (parole, PRC) are released on their POA, PRC date or as soon as possible.

Placement investigation packets are not being completed within 120 days. Many are completed within 90 days or less and some were found to be less than 14 days. (DRC 101-PLA-01)

OH 17-04 The Deputy Warden will ensure that Unit Managers and Shift Captains meet weekly. The Unit Management Administrator (UMA) will also ensure that Shift Commanders are included in unit manager staff meetings as often as possible.

The auditor reviewed the unit meeting minutes and found that documentation did not show that shift supervisors are being invited or attending the unit meetings. (DRC 74-UMA-01)

STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS 4 th EDITION		
COMPLIANCE TALLY		
	MANDATORY	NON-MANDATORY
Number of Standards	61	463
Number Non-Applicable	4	35
Number Applicable	57	428
Number Non-Compliance	3	24
Number in Compliance	54	404
PERCENTAGE OF COMPLIANCE	94.7 %	94.4 %

OHIO STANDARDS	
COMPLIANCE TALLY	
Number of Standards	68
Number Non-Applicable	18
Number Applicable	50
Number Non-Compliance	20
Number in Compliance	30
PERCENTAGE OF COMPLIANCE	66.7 %

ADULT CORRECTIONAL INSTITUTIONS 4 TH Edition ACA MANDATORY						
NOT APPLICABLE				NON-COMPLIANT		
4-4353				4-4215		
4-4362				4-4222		
4-4365				4-4400		
4-4371						
			TOTALS			
			4		3	

ADULT CORRECTIONAL INSTITUTIONS						
4 th Edition						
ACA NON-MANDATORY						
NOT APPLICABLE				NON-COMPLIANT		
4-4128	4-4285	4-4383		4-4132	4-4253	
4-4143	4-4286	4-4391		4-4134	4-4255	
4-4147	4-4287	4-4436		4-4141	4-4257	
4-4147-1	4-4307	4-4438		4-4183	4-4258	
4-4150	4-4308	4-4439		4-4184	4-4263	
4-4152	4-4309	4-4440		4-4185	4-4270	
4-4181	4-4310	4-4441		4-4192	4-4318	
4-4190-1	4-4311	4-4443		4-4200	4-4320	
4-4208	4-4312	4-4459		4-4207	4-4325	
4-4209	4-4323	4-4501		4-4230	4-4328	
4-4210	4-4353-1	4-4502		4-4234	4-4354-1	
4-4278	4-4364			4-4238	4-4425	
		TOTALS				
		35		24		

OHIO STANDARDS						
NOT APPLICABLE				NON-COMPLIANT		
01-01	14-06			04-01	12-03	
01-02	14-07			04-02	14-10	
02-02	14-08			05-01	15-01	
06-02	14-09			05-02	15-02	
06-03	15-03			06-09	15-04	
06-12	17-06			06-10	15-05	
07-03				07-02	17-01	
07-05				11-01	17-04	
07-06				11-02		
14-01				11-03		
14-02				11-04		
14-05				12-02		
		TOTALS				
		18		20		

Significant Incident Summary

Facility: LAKE ERIE CORR

Reporting Dates: 1/2012 – 12/2012

Incidents		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Assault: Offenders/ Offenders*	Indicate types (sexual**, physical, etc.)	P-0 S-0 H-0 B-0	P-0 S-0 H-0 B-0	P-4 S-0 H-0 B-0	P-3 S-0 H-0 B-0	P-4 S-0 H-0 B-0	P-3 S-0 H-0 B-0	P-4 S-0 H-0 B-0	P-4 S-0 H-0 B-0	P-0 S-0 H-0 B-0	P-0 S-0 H-0 B-0	P-0 S-0 H-0 B-0	P-0 S-0 H-0 B-0
	# With Weapon	0	0	4	3	4	3	4	4	0	0	0	0
	# Without Weapon	0	0	0	0	0	0	0	0	0	0	0	0
Assault: Offenders/ Staff	Indicate types (sexual**, physical, etc.)	P-1 S-0 H-0 I-0 B-0	P-1 S-0 H-0 I-0 B-0	P-1 S-0 H-0 I-1 B-0	P-3 S-0 H-1 I-0 B-0	P-2 S-0 H-0 I-0 B-0	P-3 S-0 H-2 I-1 B-0	P-3 S-0 H-4 I-1 B-0	P-3 S-0 H-9 I-0 B-0	P-0 S-0 H-0 I-0 B-0	P-0 S-0 H-0 I-0 B-0	P-0 S-0 H-0 I-0 B-0	P-0 S-0 H-0 I-0 B-0
	# With Weapon	1	1	2	4	2	7	9	12	0	0	0	0
	# Without Weapon	0	0	0	0	0	0	0	0	0	0	0	0
Number of Forced Moves Used***	# (Cell extraction or other forced relocation of offenders)	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*****		0	0	0	0	2	0	1	0	0	0	0	0
Number of Times Chemical Agents Used		0	0	1	2	1	1	3	5	0	0	0	0
Number of Times Special Reaction Team Used		0	0	0	0	0	0	1	0	0	0	0	0
Four/Five Point Restraints	Number	0	0	0	0	0	0	0	0	0	0	0	0
	Indicate Type	Bed	Bed	Bed	Bed	Bed	Bed	Bed	Bed	Bed	Bed	Bed	Bed
Offender Medical Referrals as a Result of Injuries Sustained	#â€™s should reflect incidents on this form, not rec or other source	0	0	2	0	0	0	0	0	0	0	0	0
Escapes	Attempted	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0	0	0	0	0	0

Health Care Outcome Measures

Standard	Outcome Measure	Numerator / Denominator	Value	Calculated O.M.
1A	(1)	Number of offenders diagnosed with a MRSA infection within the past (12) months	56	
	divided by	Average Daily Population	1599	0.04
	(2)	Number of offenders diagnosed with active tuberculosis in the past twelve (12) months	0	
	divided by	Average Daily Population	1599	0.00
	(3)	Number of offenders who are new converters on a TB test that indicates newly acquired TB infection in the past twelve (12) months	1	
	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	102	0.01
	(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	1.00
	(5)	Number of offenders diagnosed with Hepatitis C viral infection at a given point in time	147	
	divided by	Total offender population at that time	1606	0.09
	(6)	Number of offenders diagnosed with HIV infection at a given point in time	6	
	divided by	Total offender population at that time	1606	0.00
	(7)	Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART) at a given point in time	5	
	divided by	Total number of offenders diagnosed with HIV infection at that time	6	0.83
	(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	6	0.00
	(9)	Number of offenders diagnosed with an Axis I disorder (excluding sole diagnosis of substance abuse) at a given point in time	200	
	divided by	Total offender population at that time	1606	0.12
	(10)	Number of offender admissions to off-site hospitals in the past twelve (12) months	13	

Health Care Outcome Measures

Standard	Outcome Measure	Numerator / Denominator	Value	Calculated O.M.
	divided by	Average Daily Population	1599	0.01
	(11)	Number of offenders transported off-site for treatment of emergency health conditions in the past twelve (12) months	37	
	divided by	Average Daily Population	1599	0.02
	(12)	Number of offender specialty consults completed during the past twelve (12) months	300	
	divided by	Number of speciality consults (on-site or off-site) ordered by primary health care practitioners in the past twelve (12) months	678	0.44
	(13)	Number of selected hypertensive offenders at a given point in time with a B/P reading > 140 mmHg/>90 mmHg	3	
	divided by	Total number of offenders with hypertension who were reviewed	21	0.14
	(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	7	
	divided by	Total number of diabetic offender who were reviewed	67	0.10
	(15)	The number of completed dental treatment plan within the past twelve (12) months	266	
	divided by	Average Daily Population during the reporting period	1599	0.17
2A	(1)	Number of health care staff with lapsed licensure or certification during a twelve (12) months period	0	
	divided by	Number of licensed or certified staff during a twelve (12) month period.	43	0.00
	(2)	Number of new health care staff during a twelve (12) month period that completed orientation training prior to undertaking their job	47	
	divided by	Number of new health care staff during the twelve (12) month period.	47	1.00
	(3)	Number of occupational exposures to blood or other potentially infectious materials in the past twelve (12) months	5	
	divided by	Number of employees	260	0.02

Health Care Outcome Measures

Standard	Outcome Measure	Numerator / Denominator	Value	Calculated O.M.
	(4)	Number of direct care staff (employees and contractors) with a conversion of a TB test that indicated 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	#DIV/0!
3A	(1)	Number of offender grievances related to health care found in favor of the offender in the past twelve (12) months	1	
	divided by	Number of evaluated offender grievances related to health care services in the past twelve months	23	0.04
	(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 and sanitation during a twelve (12) month period.	1	0.00
	(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	1	0.00
4A	(1)	Number of problems identified by quality assurance program that were corrected during a twelve (12) month period	0	
	divided by	Number of problems identified by quality assurance program during a twelve (12) month period	14	0.00
	(2)	Number of high-risk events or adverse outcomes identified by the quality assurance program during a twelve (12) month period	0	0.00
	(3)	Number of offender suicide attempts in the past twelve (12) months	0	
	divided by	Average Daily Population	1599	0.00
	(4)	Number of offender suicides in the past twelve (12) months	0	
	divided by	Average Daily Population	1599	0.00
	(5)	Number of unexpected natural deaths in the past twelve (12) months	0	
	divided by	Total number of deaths in the same reporting period	1	0.00
	(6)	Number of serious medication errors in the past twelve (12) months	0	0.00