Exhibit 8

East Mississippi Correctional Facility (EMCF) Report

Submitted December 29, 2016

Submitted by
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Contents

Qualifications

I, Madeleine LaMarre, MN, FNP-BC, have been retained by Plaintiffs' counsel as a correctional and nurse practitioner expert to review health care services at the East Mississippi Correctional Facility. Compensation for my work is being billed at $250 per hour and ½ my hourly rate for travel time. In the following paragraphs, I have summarized my background and experience in correctional health care as a prelude to this report.

I am an independent consultant in correctional health care with more than 30 years of experience in corrections. My general qualifications as an expert are set forth in my Curriculum Vitae, attached hereto as Exhibit 1. I hold current licensure as a family nurse practitioner in the states of Georgia and New Mexico and am nationally certified by the American Nurse Credentialing Center (ANCC). I am a member of the American Nurses Association, the American Association of Nurse Practitioners, and the Academy of Correctional Health Care Professionals. I am familiar with standards of health care in correctional facilities. Beginning in 1982, I worked as both clinician and administrator of a Georgia Department of Corrections (GDC) facility providing clinical care to inmates. I later became the GDC Nursing Director providing expert clinical assistance in the planning, implementation and evaluation of nursing services. In 1995, I became the GDC Clinical Services Manager, and my responsibilities included development of health care policy and oversight of a clinical auditing program to monitor and improve the quality of health care in GDC institutions. In that role, I provided technical assistance and consultation to nurses and clinicians to achieve patient care goals. I am or have been a correctional medical expert in the states of California, Delaware and Ohio, monitoring state compliance with settlement agreements. I am currently a monitor at the Dallas (TX), Cook (IL) and Passaic (NJ) County Jails. I have served as a consultant to the Centers for Disease Control and Prevention (CDC) regarding the management of hepatitis C in correctional facilities and HIV testing implementation for correctional settings. I have authored and coauthored several publications, including serving as associate editor of Clinical Practice in Correctional Medicine, Second Edition, a textbook on correctional medicine. In this text, I authored a chapter on the nursing role and practice in correctional health care settings.

Document Review

I reviewed the following documents for this report.

1. Class Action Complaint. Jermaine Dockery et al. v. Christopher Epps et al. Civil Action No: 3:13CV326TSL-JMR. United States District Court. Southern District of Mississippi, Jackson Division. May 30, 2013.
2. East Mississippi Correctional Facility Report. Madeleine L. LaMarre MN, FNP-BC. February 25, 2011. Presley v. Epps, No. 4/05-c-00148-DAS-(ND. Miss. Nov 8, 2011). DOC. No. 151-8. Attached as Exhibit 2.
3. East Mississippi Correctional Facility Report. Madeleine L. LaMarre MN, FNP-BC. June 16, 2014. Jermaine Dockery, et al. vs. Christopher Epps, et al. No. 3:13 cv-00326-TSL-JCG. Attached as Exhibit 3.
4. Centurion MDOC Health Services Contract, effective July 1, 2015.
5. Centurion of Mississippi LLC, EMCF Health Care Policies and Procedures, Revised November 15, 2015.
6. National Commission on Correctional Health Care (NCCHC) Standards for Health Care Services in Prisons. 2014.
7. Mississippi Nursing Practice Law. Effective Date: July 1, 2010.
8. Rolando Abangan MD Mississippi License Verification. December 2016.
9. Rolando Abangan National Provider Identification Registry. December 2016.
10. EMCF Chronic Disease Roster by Third and Fourth Quarters 2015.
11. EMCF Hospital Admission Log, July 2015-February 2016.
12. EMCF Emergency Room/Hospital Admission Log, June 2015-January 2016.
13. EMCF Sheltered Housing Admission Log, July 2015-February 2016.
14. EMCF Untitled Log of Offsite Appointments, July 2015-January 2016.
15. EMCF Medical Sick Call Request Log, August 2015-January 2016.
16. Centurion Introduction to Corrections Slides.
17. Centurion Intake Health Care Screening/Intake Screening Training Slides.
18. Centurion Employee Orientation: Healthcare Screening Post Test Answer Key.
19. Centurion CQI Reports, July and August 2015 and related correspondence.

Overview

On July 11-15, 2016 I visited the East Mississippi Correctional Facility (EMCF) in Meridian, Mississippi. EMCF is a private prison operated by Management Training Corporation (MTC). The facility has an authorized capacity of 1362 inmates, expandable to 1500 inmates.[1] Centurion of Mississippi, Inc. provides health care services. EMCF has a specialized mission of providing psychiatric services and individualized and group counseling.

The purpose of my visit was to assess whether EMCF inmates received adequate health care for their serious medical and mental health conditions.

I was accompanied by Marc Stern, MD, a correctional medical expert; Gabriel Eber of the ACLU; Alesha Judkins and Sam Weiss of the Southern Poverty Law Center (SPLC); and Erin Monju of Covington & Burling LLP.

I performed the following activities in preparation for and during the site visit:

- Reviewed the class action complaint alleging inadequate medical and mental health care at EMCF
- Toured EMCF inmate housing units, main and satellite medical clinics
- Interviewed health care and custody staff
- Interviewed inmates
- Observed medication administration by nursing personnel
- Reviewed inmate health records
- Reviewed the MDOC Centurion Health Services Contract, effective July 1, 2015
- Reviewed Centurion Health Care Policies and Procedures
- Reviewed other medically related documents

I selected health records from various tracking logs provided by defendants in discovery, including nurse and physician sick call, chronic disease, emergency room visits and hospital admissions logs. I reviewed over 300 separate health encounters in 20 health records. These encounters represented various health care systems, including intrasystem transfers, nurse sick call, physician encounters, chronic disease management, infirmary care, specialty services, urgent and post-hospitalization care, medication administration records, and laboratory and diagnostic reports. I reviewed each record for the timeliness, appropriateness and quality of care, and assessed whether health care systems functioned in an integrated manner.

I would like to thank Frank Shaw, Warden, and Ollie Little, Health Services Administrator, and Centurion staff for their assistance in conducting this review.

[1] Mississippi Department of Corrections website. September 19, 2016.

Executive Summary

The Mississippi Department of Corrections (MDOC) has chosen to concentrate a large population of seriously mentally ill inmates, many of whom also have serious medical illnesses, at EMCF. Providing adequate health care for this high-acuity medically and mentally ill population requires that EMCF have an adequate structure for providing health care services, including site specific health care policies and procedures; adequate numbers and types of staff; staff training; and a functional quality improvement program designed to identify problems and implement strategies to correct them. In addition, an adequate health care delivery system requires that the components of a health care system function in an integrated manner. As summarized below, EMCF has for some time failed on each of these measures.

This is my third report regarding health care services at EMCF. I submitted my first report in 2011, when GEO provided health care services. My second report was submitted in 2014, when Health Assurance, LLC provided health care services. In my two previous reports, I identified systemic issues with the health care system at EMCF that resulted in failure to provide timely and appropriate health care to inmates with serious medical needs. Those systemic issues resulted in actual harm to individual patients, and created a substantial risk of serious harm to all EMCF patients. I have reviewed and relied on these prior reports and underlying documents when preparing this report, and have attached them here as Exhibits 2 and 3.

Since my last report in June 2014, MDOC has established a new statewide health services contract with Centurion of Mississippi, LLC. The contract became effective on July 1, 2015, and I have limited the time frame of this report to the period after Centurion took over the provision of care. With the implementation of the new contract and vendor, I note some improvement from previous site visits. This includes registered nurses performing sick call assessments and optometry care being provided by licensed optometrists. However, systemic issues remain at EMCF that result in patients not receiving timely and appropriate care for their serious medical conditions. These issues are of such magnitude to have either caused harm (e.g., preventable hospitalizations, etc.) or created an ongoing risk of serious harm to patients.

These issues include:

- Lack of timely access to a licensed medical provider licensed to diagnose and treat patients' serious medical conditions.
- Lack of adequate medical evaluations, treatment and monitoring of patients with serious medical conditions.
- Lack of adequate physician oversight of nurse practitioners.
- Registered nurses and licensed practical nurses exceeding their scope of practice.
- Lack of space, equipment, and supplies sufficient to provide adequate care.
- Failure to properly screen patients for serious medical, dental and mental health conditions upon transfer to EMCF, and to provide continuity of care.
- Lack of timely medical staff review and follow-up of abnormal laboratory reports.

- Lack of timely and appropriate care for chronic disease patients, and failure to monitor and treat patients in accordance with their degree of disease control.
- Failure to timely follow-up with patients following hospitalizations and specialty services.
- Failure to properly admit, physically examine and monitor infirmary patients.
- Lack of sufficient medical bed space for medical and mental health patients requiring infirmary care.
- Lack of timely access to dental care and insufficient dentist staffing.
- Lack of complete and accurate health records.
- Systemic issues with medication administration that include medication delays, discontinuity of chronic disease medications, and lack of response to patient nonadherence.
- Failure to adapt Centurion's health care policies and procedures to provide site-specific operational detail to staff necessary to implement the policies at EMCF.
- Lack of an adequate quality improvement program.
- MDOC's failure to provide a robust contract monitoring oversight program to ensure that health care vendors provide adequate health care for patients with serious medical conditions that meets community standards and complies with policies and procedures as well as contract requirements.

I address each of these issues in the body of my report.

However, one issue bears emphasis. A persistent concern in my reviews of EMCF has been the failure of physicians at EMCF to medically evaluate, treat and monitor patients with serous medical conditions.

In correctional facilities, patients tend to have higher medical and mental health acuity as compared to patients in the general community. The health needs of correctional patients are typically of a primary care nature (e.g., high blood pressure, diabetes, etc.), which warrants medical providers[2] credentialed[3] in internal medicine or family practice. But at EMCF, patients do not have access to a physician who is credentialed in primary care. Instead, the physician, Dr. Rolando Abangan, is a retired neurosurgeon[4] who delegates the treatment of the most medically complicated patients (e.g., chronic disease patients) to nurse practitioners, while

[2] A medical provider is a physician or nurse practitioner.

[3] Credentialing is a process by which a physician's qualifications are evaluated by reviewing their education, training, licensure, malpractice history and professional competence with respect to work they are expected to perform. Credentialing protects patient safety by preventing incompetent, poorly trained, or impaired physicians from engaging in patient care. The credentials and training of a physician determine what type of privileges a physician should have. For example, a physician trained in obstetrics can be privileged to deliver babies and a surgeon privileged to perform appendectomies. As a result, a hospital would not credential an obstetrician to perform abdominal surgery, nor credential a surgeon to deliver babies. This is because the credentialing and privileging process is to ensure that physicians practice in specialties for which they have been trained.

[4] Dr. Abangan's National Provider Identification (NPI) Registry lists his specialty as family medicine not neurosurgery. This is not consistent with the Mississippi Board of Medical Licensure verification that lists his specialty as neurosurgery.

seeing the less medically complicated patients himself (e.g., sick call referrals). Moreover, while adult and family nurse practitioners are primary care trained and credentialed to treat EMCF patients, the physician – who should be supervising them – is not, and therefore cannot provide adequate supervision. As a result, when nurse practitioners' practice places patients at risk of harm, as I frequently found in my review of care provided to chronic disease patients, the physician does not play a role in identifying the problems and implementing remedial training to improve care.

In addition, independent of the patient's medical complexity, my review showed that in case after case, the physician failed to medically evaluate, treat and monitor patients with serious medical conditions, including patients presenting urgently with life-threating conditions (e.g. uncontrolled diabetes and acute renal failure[5]). While the physician's lack of credentialing in primary care is a contributing factor, I found that the physician's lack of medical evaluations and follow-up for seriously ill patients to fall well below even a minimally acceptable standard of care.

The deficiencies in this physician's medical practice are known to MDOC. He was employed at EMCF when I performed my first review of the facility in 2011. At that time, I noted the physician's failure to evaluate patients with symptoms of serious medical conditions or to timely follow-up on abnormal laboratory test results. I discussed my concerns with GEO's Chief Medical Officer, Cassandra Newkirk MD, who shared my concerns and indicated that GEO's internal peer review showed that the physician's practice was below the standard of care, and they sought to replace him. At some point in time, Dr. Abangan was no longer employed at EMCF, but disturbingly, Centurion has re-hired this physician.

The hiring of this physician to treat EMCF patients raises serious questions about Centurion's credentialing and hiring process, as well as MDOC's oversight of health care delivery at EMCF. According to the MDOC/Centurion medical contract, MDOC has the right to approve key Centurion personnel. Yet MDOC – despite knowing of the physician's lack of credentials as a primary care provider and his previous performance at EMCF – permitted Centurion to hire him again at EMCF. And, unsurprisingly, this review shows the very same problems identified in 2011: the physician's failure to perform adequate medical evaluations, failure to timely follow-up on patient's abnormal lab reports, and failure to timely follow-up with patients following hospitalizations and receipt of specialty services.

Thus, as noted in my last report and in addition to the issues discussed below, there remains a significant risk of harm to EMCF patients due to the physician's care of patients and the absence of meaningful supervision of the practice of the nurse practitioners.

[5] Patient #3.

Findings

Access to Care

As a general matter, access to care involves patients being timely evaluated by a health care professional licensed to diagnose and treat their medical, dental and/or mental health conditions, as appropriate. Timely access to care is a fundamental requirement of health care delivery. To review access to care at EMCF, I toured housing units, main and satellite medical clinics; reviewed health records; and interviewed custody, health care staff, and inmates. My review showed that EMCF patients do not have timely access to care for their serious medical and dental conditions, posing a significant risk to patient health.

Clinic Space, Equipment and Supplies

Providing adequate health care requires an infrastructure to deliver care. This involves having adequate numbers of medically equipped and supplied examination rooms, as well as medical beds (e.g. infirmary) to provide care for acutely ill medical and mental health patients.

To assess this area, I toured the main medical and satellite clinics, infirmary, and dental and intake areas. That review showed that EMCF's clinical, dental and infirmary space, and equipment and supplies are insufficient to provide adequate health care to the EMCF population.

In my tour of EMCF's medical facilities, I found that there is an insufficient number of infirmary beds to manage patients with acute medical and mental health conditions – the primary population served by EMCF. As a consequence, staff send acutely ill medical and mental health patients back to their housing unit instead of admitting them to the infirmary where their medical and/or mental health condition can be monitored and treated. In one case, a patient who was catatonic and refusing meals and insulin was left in his housing unit where his condition steadily deteriorated until he developed acute renal failure.[6] In another case, health care staff repeatedly treated a patient with severe chronic obstructive pulmonary disease (COPD) and then sent him back to his housing unit instead of admitting him to the infirmary for monitoring and treatment. As a result of his inadequate treatment, the patient was hospitalized multiple times for his poorly controlled COPD.[7]

Infirmary rooms also lack functional alarms for patients to notify health care staff in the event of an emergency, creating a daily and ongoing risk of harm to patients. Although cameras are installed in the infirmary hallway for correctional officers to monitor patients in their rooms,

[6] Patient #3
[7] Patient #2.

infirmary room windows are damaged and opaque, such that correctional staff cannot see into the rooms to detect a patient in distress. Sanitation in infirmary rooms is also poor, creating a risk of infection.

The infirmary is often full, and overflow infirmary patients are placed in a holding room that does not have a bed, sink or toilet. The light in the room is on 24 hours a day, interfering with patients' sleep. The lack of the most basic items such as a bed and toilet for acutely ill medical and mental health patients demonstrates a troubling lack of concern as to their most basic needs. Overflow patients are also housed in the Intake Unit, which is not routinely staffed by health care or correctional staff and does not provide a means for patients to notify staff in the event of an emergency, creating yet another daily and ongoing risk of serious harm to patients. Moreover, these rooms are unsanitary, presenting risk of infection to patients, and lack beds – with only mats on the floor for patients to sleep on, which is not appropriate for an acutely ill medical patient.

Medical clinics are also not standardized with respect to medical equipment and supplies, impeding adequate examinations of patients. For example, the physician's office is not properly medically equipped and supplied. There is no oto-ophthalmoscope or blood pressure cuff in the room. There is an exam table but no exam table paper to use between patients to provide infection control. The physician's office has a window that has no blind and provides no privacy during physical examinations. There is also no sink or hand sanitizer in the physician's office to provide access to handwashing, creating further risk of infection. This lack of basic medical equipment in the physician's exam room not only imperils adequate examination and treatment of patients, but is also inconsistent with the physician's documentation of complete medical examinations, as this would require using equipment not available to him in the room.[8]

The room used to perform examinations of chronic disease patients also does not contain an oto-ophthalmoscope, disposable ear speculums or tongue blades. There was a peak flow meter, but no disposable mouth pieces to enable providers to measure airflow obstruction in patients with asthma and COPD. This prevents medical staff from accurately assessing patients' disease control in order to make treatment decisions.

While the satellite medical clinics were generally better equipped and supplied, they were also not stocked with peak flow meters to assess patients with acute or chronic respiratory conditions.

In addition, newly arriving inmates are not medically screened in a medical clinic. Nurses medically screen inmates in the Intake Unit or gymnasium where there is no examination room that is medically equipped and supplied, that provides patient privacy, or that permits access to

[8] The physician, despite not having an oto-ophthalmoscope, documents complete examinations of the ears and eyes. This also raises questions about the accuracy and integrity of the medical record.

the electronic medical record. This has resulted in inadequate medical screening and lack of continuity of medical care.

Further, dental operatory equipment and furniture was in an unacceptable condition. Dental chairs were rusted and thus did not enable adequate infection control, creating an unacceptable risk of infection for EMCF patients. The rooms were dirty and cluttered. The x-ray developer and file cabinets were also rusted. Cabinetry was falling apart. Instruments, including sharp instruments, in the dental area were unsecure and not counted, presenting a risk that inmates would gain access to sharps that could be used as weapons against staff or other inmates.

In summary, the lack of adequate infirmary beds has resulted in acutely medically and mentally ill patients being placed in a non-medical bed (e.g. Overflow room or Intake Unit) or sent back to a general population bed where they do not receive adequate monitoring and treatment for their serious medical conditions, resulting in deterioration of their conditions and preventable hospitalizations. The lack of standardized medical equipment and supplies results in inadequate medical evaluations. The failure to replace rusted dental equipment presents a risk of infection to EMCF patients; and the failure to secure sharp dental instruments presents a risk that inmates will gain access to sharps to be used as weapons against staff and other inmates.

Intrasystem Transfer Screening

At EMCF, patient access to health care begins following transfer from another correctional institution. Nurses conducting transfer screening are to identify an inmate's health care needs and facilitate continuity of care. This includes noting the patient's medical, dental and mental health conditions, current medications, pending or recently completed specialty services, and need for enrollment into the chronic disease program. However, these steps do not reliably take place at EMCF. This increases a risk of harm to patients from lack of continuity of medical, mental health or dental care.

According to Centurion policy,[9] transfer screening is to take place within 12 hours of arrival; however, this does not always take place. In one case, nurses did not medically screen a mental health patient for over 24 hours after his arrival at EMCF, resulting in delayed ordering and administration of his psychotropic medications.[10] Since many mental health patients are transferred to EMCF precisely because their mental health conditions are poorly controlled, delays in administration of their medications may cause further decline in their condition, resulting in violence towards staff, other inmates or themselves.

[9] Healthcare Transfer Screening. E-03. November 2, 2015. The policy does not include operational detail of where intrasystem transfer screening is to be conducted.
[10] Patient #1.

As noted above, EMCF security staff process new arrivals at the Intake Unit and notify health care staff to come to the Intake Unit or gymnasium to perform the transfer screening. Of concern is that this screening is not performed in a medical area (e.g., examination room) that provides privacy. Nor does the nurse have access to the patient's medical record when performing the screening. The lack of immediate access to the patient's medical record at the time of the screening prevents the nurse from knowing the patient's previous medical history, including chronic diseases, current medications, and the need for medical follow-up for hospitalizations or specialty services (e.g., cardiology). The lack of the nurse's contemporaneous access to the patient's medical record means that the nurse cannot document an assessment in real time and creates a risk that the nurse will not facilitate the timely renewal of the patient's medications or enroll a patient with serious medical and/or mental health conditions into monitoring programs, and that his condition will not be timely treated, thus creating a risk of harm to the patient.

The following cases are illustrative: In one case, a nurse noted that the patient denied medical and mental health conditions, but his medical record showed that he had a history of schizophrenia and previously took psychotropic medications. The nurse also failed to note that the patient was being evaluated to determine whether he had HIV infection.[11] In another case, the nurse did not take vital signs, or note the patient's chronic diseases or current medications.[12] In two cases, patients with a history of hypertension were not enrolled into the chronic disease management program and, as of July 2016, neither a physician nor nurse practitioner had seen the patients for management of their hypertension.[13] In another case, the nurse did not refer a patient with a history of mandibular fracture requiring specialty services for follow-up with the physician.[14] The lack of consistent and adequate transfer screening in each of these cases resulted in discontinuity of care for the patients' serious medical conditions, posing significant risk to their health.

Routine Access to Care

At EMCF, when inmates want treatment for a medical, mental health or dental condition, they are required to submit a medical services request form (MSR), sometimes referred to as a sick call request, to receive initial access to care. This system is to permit health care staff to review the request and to determine the type of service needed as well as the urgency of the request (e.g., routine, urgent or STAT).

Centurion policy[15] states that inmates should submit the MSRs into secure boxes accessed only by health care staff. Staff are to collect and triage the forms within 24 hours and schedule the patient to be seen in accordance with the urgency of his complaint. The policy also states that

[11] Patient #11.
[12] Patient #9.
[13] Patients #7 and 18.
[14] Patient #1.
[15] Non-Emergency Health Requests and Services. E-07. Revised November 2, 2015.

"The sick call system is conducted in a manner to protect the confidentiality of the patient request."

However, during tours of the housing units, inmates I interviewed universally reported that they gave their MSRs to the correctional officers who then placed the requests in the sick call box, which is located *outside* inmate housing units. Thus, the current practice does not ensure that inmates' health requests are delivered unimpeded to health care staff and are not kept confidential in accordance with EMCF policy. During my site visit, some inmates also reported that they submitted multiple MSRs without receiving a response from health care staff – whether this was a lapse by officers, medical staff or both was not possible to determine, but regardless, failure to respond to these requests places patient health at risk of harm.

My review of 30 MSRs showed that, when MSRs are responded to, sick calls are performed by registered nurses (RNs), who are trained and licensed to perform such assessments, instead of licensed practical nurses (LPNs), who are not. This is a significant improvement since the site visits of 2011 and 2014. RNs generally collected, triaged and assessed patients timely with the exception of patients with dental pain, as discussed below.

However, nurses perform health assessments in examination rooms lacking access to key medical equipment (e.g. peak flow meters) needed to assess patients with acute or chronic respiratory conditions. Further, while treatment protocols were made available to the nurses for guidance in treatment of common complaints, nurses independently ordered antibiotics (e.g., Bactrim) and x-rays without consulting a physician. However, in the State of Mississippi, registered nurses are not licensed to independently order antibiotics and x-rays.[16] The practice is also not in compliance with Centurion policy[17] or NCCHC Standards. The nurses' practice of independently ordering antibiotics and x-rays reflects that patients are not provided timely access to a medical provider qualified to diagnose and treat the patients' condition, and increases patients' risk of harm from delayed diagnosis and treatment by a qualified medical provider.

The quality of nursing assessments was also variable and, in several cases, inadequate. When nurses referred patients to the physician, in most cases, the nurse did not document the urgency of the referral (i.e., routine, urgent, STAT) and, in several cases, the referral did not occur in accordance with the severity of the patient's condition. Of particular concern is that nurses did not address and refer patients with abnormal and potentially life-threatening vital signs. These practices created both a risk of and actual harm to patients.

The following are examples of the above issues:

[16] Mississippi Nursing Practice Law. Effective July 1, 2010.
[17] Nursing Assessment Protocols and Guidelines. E-11. Revised November 2, 2015.

- On October 13, 2015, a 49-year-old patient with a history of COPD submitted a MSR to see the doctor because his breathing was painful and he had a "hole in his lung."[18] The patient wrote "Please help me." The patient's vital signs were abnormal (pulse=107/minute, respirations=26/minute) and his oxygen saturation dangerously low (SpO2=79%, normal=95-100%). The nurse referred the patient to the physician who did not medically evaluate the patient. Without examining the patient to establish a medical diagnosis and determine the severity of his condition, the physician treated the patient with antibiotics and oral steroids. That same day, a LPN ordered a chest x-ray. The next day, again without medically evaluating the patient, the physician ordered intramuscular steroids. The patient's chest x-ray showed severe COPD and Cor pulmonale without infiltrates[19]. On October 15, 2015, the physician signed the patient's x-ray report but did not see the patient to assess whether his condition had improved. This patient had a serious medical condition for which the physician did not medically evaluate the patient or provide any follow-up. This patient was hospitalized three times for his poorly controlled COPD before he was transferred to the Mississippi State Penitentiary (MSP).

- On January 14, 2016, a 62-year-old man with a history of diabetes, hypertension and schizophrenia requested "something" for his stomach.[20] His blood pressure was severely elevated (BP=176/81 mm Hg, normal=<140/90 mm Hg), but the nurse did not address or refer the patient to the physician for his poorly controlled hypertension. Poorly controlled hypertension increases the risk of heart attack, stroke and kidney failure.

- On February 16, 2016, a nurse saw the same patient who had submitted a request for a "cold pack." The patient's vital signs were abnormal, including severely elevated blood pressure and heart rate (BP=180/81 mm Hg, normal=<140/90 mm hg, pulse=114/minute, normal=60-100/minute). The nurse did not take a history of the patient's onset of symptoms, perform a pulmonary review of systems (e.g., ask the patient whether he had fever, shortness of breath, cough, sputum production etc.), or measure his peak expiratory flow rate (PEFR).[21] The nurse documented that the patient's chest was clear and treated him with an antihistamine. The nurse did not address or refer the patient to a physician for his grossly abnormal vital signs. As noted, above, this increases the risk of harm to the patient by not providing timely diagnosis and treatment for poorly controlled hypertension and abnormal pulse.

[18] Patient #2.
[19] Cor pulmonale is right sided heart disease that occurs as a result of severe pulmonary disease.
[20] Patient #3.
[21] The Peak Expiratory Flow Rate (PEFR) measures how much airway obstruction is present. There is variation in normal values depending on age, gender, and height. For patients with respiratory disease (e.g. asthma and COPD), the typical approach is to measure the patient's best performance and document the value in the health record, and then remeasure the patient's PEFR during acute episodes to determine the severity of illness.

- On March 11, 2016, a 66-year-old diabetic submitted a request stating that his feet were hurting.[22] The nurse documented "No S/S (signs or symptoms) infection" but did not document an examination of the patient's right and left foot, either as to infection (e.g., redness, swelling, ulcers, etc.) or circulation (e.g., temperature, pedal pulses, etc.). The nurse simply referenced that the patient was under care for a callous. The failure of the nurse to examine and describe the patient's foot increased the risk that the patient would not be timely diagnosed and treated for a diabetic ulcer, which can result in infection and amputation of the affected limb.

- On January 18, 2016, a 40-year-old patient submitted a MSR complaining of having a bad cold and a sore throat. On January 19, 2016, a RN saw the patient. The patient had a runny nose, sore throat and head congestion and was coughing up phlegm. The nurse did not take a history of onset or duration of the patient's symptoms. The nurse did not ask about the quality and quantity of his sputum. The nurse did not examine the patient's eyes, ears, nose or throat, or neck for swollen lymph nodes. The nurse documented only that the patient's chest sounded clear. The patient's blood pressure was high (BP=148/95 mm Hg, normal=<140/90 mm Hg), but the nurse simply gave the patient over-the-counter medications. The nurse did not properly assess this patient to determine whether he had symptoms of a more severe lung infection, address the patient's elevated blood pressure, or refer the patient to a provider for evaluation and treatment of his pulmonary condition and poorly controlled hypertension.[23]

- On January 26, 2016, the same patient submitted a MSR stating that his mouth and face were swollen after he put soap on them. That day, a RN saw the patient noting that the left side of his mouth and face were swollen from above the left lip to his lower jaw. The patient complained of severe pain (10 out of 10 in severity). The nurse gave the patient Ibuprofen and referred the patient to a physician, but did not specify the urgency of the referral. Because of the patient's significant facial swelling and severe pain, the nurse should have urgently referred the patient to the provider.

- On the evening of January 26, 2016, at 7:00 pm, an LPN saw the same patient urgently for a boil to his left upper lip that was red, swollen and hot to touch. He was unable to eat or sleep due to the pain. Although the patient clearly had an infection, the LPN did not measure his vital signs and did not notify the physician at that time. Instead, the LPN ordered an antibiotic (Bactrim) per protocol that was not cosigned by the physician. Thus, the LPN independently ordered oral antibiotics for this patient, which is beyond the scope of practice for a LPN (or RN). The next day, the physician saw the patient and treated him for herpes simplex. The following day, on January 28, 2016, the patient was admitted to the hospital for a severe facial infection and underwent surgery to drain infection from his lip,

[22] Patient #4.
[23] Patient #5.

nasal labial fold, cheek and forehead. This patient had a rapidly progressing and severe facial infection for which admission to the hospital was delayed.

- On March 16, 2016, the same patient submitted a MSR complaining of a cold and sore throat so severe he was unable to swallow his food, noting "Please help me." The MSR was received on March 17, 2016, and a RN saw the patient the next day. The nurse documented that the patient's throat was red and sore. The nurse did not describe the presence or absence of purulence (i.e. pus) in the patient's throat or palpate his neck for enlarged lymph nodes. The nurse gave the patient over-the-counter medications. The nurse did not refer the patient to a physician. Given the patient's severe throat pain, difficulty swallowing and recent hospitalization for facial cellulitis, the nurse should have consulted the physician as this may have represented an undiagnosed pharyngeal (i.e., throat) abscess.

- On November 23, 2015, a 53-year-old patient with glaucoma[24] submitted a MSR stating that his glaucoma eye drops (Latanoprost) were stolen from under his mattress, and that his eyes were hurting and he needed it refilled. The nurse did not see the patient to assess his eye pain. Seven days later, on November 30, 2015, the psychiatrist reordered his glaucoma eye drops and levothyroxine (thyroid medication).[25] On December 3, 2015, the patient was given eye drops. The nurse should have seen the patient to evaluate his vision and eye pain to determine whether he had vision loss requiring urgent referral to a medical provider. In addition, the patient did not timely receive his glaucoma medication, which may cause increased pressure in the eye and deterioration of the patients' vision.[26]

- On September 11, 2015, a 43-year-old patient with HIV infection submitted a MSR complaining of wanting his psychotropic medication times changed.[27] On September 12, 2015, an RN saw the patient. The patient's diastolic blood pressure was significantly elevated (BP=140/108 mm Hg, normal=140/90 mm Hg). The nurse documented that the patient had dental problems, vision difficulties, difficulty urinating and had mouth irritation. The nurse did not assess any of these complaints, but referred the patient to mental health. The nurse did not address the patient's increased blood pressure or refer the patient to the physician. This patient did not receive a timely medical evaluation for his potentially serious medical conditions.

These cases reflect that nurses perform inadequate patient assessments, do not timely refer patients with serious medical conditions to a medical provider, and exceed their scope of practice by ordering prescription medications in violation of the Mississippi Nursing Practice

[24] Glaucoma is an eye disease in which eye pressure increases, causing loss of vision.
[25] It is unusual for a psychiatrist to renew medications for the treatment of medical conditions, because the psychiatrist does not medically evaluate these conditions. Typically, a medical provider renews medications in association with a chronic disease visit in which the medical provider determines whether any changes in the treatment plan are warranted. This did not occur for this patient.
[26] Patient #7.
[27] Patient #8.

Law and Centurion Policy and Procedures.[28] Coupled with the care provided by the physician, addressed above, the result is that EMCF patients have experienced harm from delayed diagnosis and treatment of their serious medical conditions.

Chronic Disease Management

Incarcerated populations have a high prevalence of chronic diseases such as diabetes, hypertension, asthma, chronic obstructive pulmonary disease, seizure disorders, and HIV and hepatitis C infection. Routine monitoring and treatment is necessary to prevent the complications of these chronic conditions. The frequency of patient monitoring is determined by the patient's degree of disease control. For example, patients with poorly-controlled hypertension should be monitored more frequently than patients with well-controlled hypertension in order to assess patient's response to the treatment regimen and adjust their medication accordingly. Therefore, it is important that health care staff enroll eligible patients into the chronic disease program upon arrival so they can be timely monitored and treated.

I evaluated the management of patients with chronic diseases at EMCF by reviewing applicable policies and procedures, chronic disease tracking logs and 35 chronic disease encounters in 20 patient records. My review showed that EMCF patients do not receive timely and appropriate care for their chronic diseases. Consequently, some patients experienced poor disease control, resulting in risk of harm from complications and preventable hospitalizations.

As an initial matter, my review showed that not all patients with chronic diseases are enrolled into the chronic disease program. Two chronic disease patients have been at EMCF since 2014 and 2015, respectively, but as of my visit in July 2016, had never been seen by a physician or nurse practitioner for chronic disease management.[29] In addition, registered nurses also do not refer patients with poorly controlled chronic diseases (e.g., hypertension) seen at sick call to medical providers for evaluation and treatment. These patients are at risk of complications of hypertension such as heart attack, stroke and kidney disease as a result of not being timely monitored and treated.

In addition, as described above, nurse practitioners manage all patients with chronic diseases, and the physician is not involved in their routine care. Although nurse practitioners are trained and credentialed to treat chronic diseases, the physician should be involved in the care of medically complicated patients to ensure care is timely and appropriate. This does not occur at EMCF. This was supported by my record review – health records do not reflect that the nurse practitioners and physician communicate regarding chronic disease patients, even when patient's chronic diseases are poorly controlled, resulting in hospitalizations.

[28] Mississippi Nursing Practice Law. Effective July 1, 2010.
[29] Patients #7 and #18.

Nurse practitioners also do not consistently perform adequate evaluations of chronic disease patients, which include pertinent review of systems (ROS)[30] and physical examinations for all chronic diseases at each visit. Labs are not coordinated to be drawn prior to chronic disease visits and are typically drawn after the chronic disease visit. Thus when labs are abnormal, the nurse practitioners do not address the report until the next visit, several months later.[31] Nurse practitioners also do not consistently reference in their notes lab values (e.g. hemoglobin A1C for diabetics, etc.) or diagnostic tests that are needed to support assessments of disease control and continuation or amendment of treatment plans. Nurse practitioners do not consistently follow nationally recognized guidelines (e.g., American Diabetes Association) for evaluation and treatment of chronic illnesses, or monitor patients in accordance with their disease control. For example, nurse practitioners do not perform or order foot exams using monofilament testing, or ensure that diabetics have annual eye examinations, both which are necessary to detect and treat complications of diabetes. The lack of adequate medical evaluation and adherence to national guidelines increases the risk of complications and harm to the patient. Moreover, due in part to their design, electronic medical record (EMR) clinical notes are confusing, and it is difficult to discern current clinical information from old clinical information that is no longer valid.

Record review also shows disruptions in medication continuity for chronic disease patients, contributing to poor disease control and increasing the risk of complications of their chronic diseases. Moreover, for patients who are not compliant with taking their medications, medical staff do not timely address the nonadherence to determine the reasons for the nonadherence (e.g., troublesome side effects, etc.). Monitoring and addressing medication nonadherence is important in any setting, but particularly important at EMCF because the majority of the EMCF population is mentally ill. Due to their mental illness, these patients are more likely to have difficulty being compliant with their medications and require close monitoring. And for patients with chronic disease, lack of medication adherence or disruptions in renewing medications increases the risk of poor disease control and complications.

The following are examples of the above issues, in addition to the record review summaries attached to this report. Of note, the first case is egregious and further described in the infirmary section of this report:

[30] A review of systems (ROS) is when a medical provider or nurse asks the patient if they have symptoms or signs related to a given medical condition – for example, asking a patient with heart disease whether they have chest pain, shortness of breath, palpitations or ankle swelling. Performing a ROS is a standard component of a medical evaluation to determine whether the patient's medical condition is worsening or improving, and whether the patient's treatment plan should be continued or changed.

[31] Coordinating labs to be drawn and results available in advance of the patient's chronic disease visit enables the medical provider to incorporate the information into the assessment of the patient's disease control. The failure to coordinate labs to be drawn in advance of the visit results in incomplete information available to the provider and inaccurate assessments of disease control. Moreover, for labs obtained after the visit that are abnormal, providers do not timely address them by recalling the patient and changing the treatment regimen, increasing the risk of complications and harm to the patient.

- This 62-year-old man arrived at EMCF in 2009 and transferred to MSP on April 28, 2016. His medical history includes diabetes, hypertension, hypothyroidism, asthma and schizophrenia.[32] On October 11, 2015, a NP saw the patient for chronic disease management but did not address all of his chronic diseases. The NP did not inquire about cardiovascular symptoms such as chest pain, shortness of breath or palpitations. The patient's blood pressure was also significantly elevated (BP=174/101 mm Hg and pulse=89/minute). The NP assessed the patient's hypertension as being in poor control, and included in his record a template instruction for poorly controlled hypertension "to admit to infirmary or perform daily BP monitoring until BP was <160/100 mm hg." This did not occur. The NP also ordered labs, medications, weekly blood pressure checks and follow-up in 2 weeks. The 2 week follow-up did not take place as scheduled. In early December 2015, the patient became catatonic, refused insulin, fluids and meals. On December 28, 2015, the psychiatrist admitted the patient to the infirmary. On December 30, 2015, the patient's blood sugar was extremely elevated (542, normal=100-140) and labs showed he was in acute renal failure. The nurse contacted the physician who ordered the patient sent to the hospital in a van, instead of an ambulance. When the van arrived at the hospital, the patient, who was still catatonic, "refused" to get out of the van and was brought back to EMCF without medical treatment. The physician saw the patient after the patient was sent to the hospital (but not treated), but did not treat the patient's acute renal failure, poorly controlled hypertension or diabetes. A NP did not see the patient for chronic disease management again until January 14, 2016. On April 10, 2016, a NP saw this patient for chronic disease management. The patient's blood pressure was still high (BP=160/90 mm Hg). The NP took an asthma review of systems, but not one for cardiovascular, diabetes or thyroid disease. She did not change the patient's blood pressure medication because he had not taken his medication that morning. She planned to see the patient again in 3 months. This follow-up time frame was not appropriate given that the patient's hypertension was not controlled. This patient is at risk of heart attack, stroke and kidney disease due to lack of timely monitoring for his poorly controlled hypertension.

- This 53-year-old man arrived at EMCF in December 2014.[33] His medical history includes hyperthyroidism/hypothyroidism[34], hypertension, depression, hyperlipidemia[35] and glaucoma. The patient's glaucoma diagnosis was not noted on the Problem List[36], increasing the risk that providers would not be aware of and monitor this condition. Despite suffering from multiple chronic diseases, he was not enrolled into the chronic

[32] Patient #3.
[33] Patient #7.
[34] Hyperthyroidism is a condition in which the thyroid gland produces too much thyroid hormone. After treatment of hyperthyroidism, many patients become hypothyroid, in which the thyroid gland produces an insufficient amount of thyroid hormone. These patients require thyroid supplements in the form of a medication called levothyroxine.
[35] Hyperlipidemia is high cholesterol.
[36] The Problem List is a document in each patient's medical record to record the patient's significant medical, mental health and dental diagnoses.

disease program upon arrival at EMCF, and his chronic disease medications were not initially ordered, causing a lapse for several months. After several months, a medical provider ordered hypertension medication for the patient but without medically evaluating the patient. In addition, at his previous correctional facility, optometry recommended that he have an optometry follow-up for his glaucoma no later than February 2015, but this did not take place. In August 2015, the patient's labs showed his hypothyroidism was not at goal, but a medical provider did not address this abnormal report. On October 28, 2015, the physician saw the patient for follow-up of chest pain, but did not note that the patient had hypertension and hyperlipidemia, which are risk factors for heart disease. On December 10, 2015, the patient's medication orders expired (for amlodipine and hydrochlorothiazide). Yet, nurses kept giving these medications to the patient without a physician order, until December 18, 2015. Then the patient did not receive any medication until December 22, 2015, when his medications were reordered. Since the patient's arrival at EMCF in December 2014, a provider has not seen the patient for chronic disease management, he has had discontinuity of chronic disease medications and his hypothyroidism is not at goal. As a result, the patient is at risk of complications of his chronic diseases.

- This 42-year-old man, with a medical history including hypertension and bipolar disorder, arrived at EMCF on September 4, 2015.[37] That day, a nurse medically screened the patient. The nurse did not document in his record that he had hypertension or whether any medications had been transferred with him, but the same day, a medical provider nonetheless ordered medications for him for high blood pressure and bipolar disorder (i.e., hydrochlorothiazide and Risperdal). Five days later, on September 9, 2015, the physician saw the patient and performed a physical examination devoid of any medical history (i.e. noting his hypertension), and failed to document the patient's medical diagnosis or a treatment plan. The physician also did not enroll the patient into the chronic disease program. Blood pressure measurements over the next few months showed the patient's hypertension was not well controlled (December 8, 2015: BP=158/97 mm Hg; June 2, 2016: BP=132/100 mm Hg). The patient's October and November 2015 Medication Administration Records (MARs) show that he was not taking either of his medications, citing the patient as a "No Show"[38], yet staff took no action to address the patient's nonadherence. Since the patient had not been enrolled into the chronic disease clinic, it is unclear whether the patient was even aware that medication had been prescribed for treatment of his hypertension. The patient's medication order for hydrochlorothiazide expired on March 4, 2016 and had not been renewed at the time of my July 2016 review. Thus, at the time of my review, the patient had been at EMCF for over 9 months, but a medical provider had never seen the patient for chronic disease management. As a result,

[37] Patient #18.

[38] A "No Show" is when a patient is scheduled for a medical appointment or treatment (e.g. medications) but does not appear for the appointment. "No Shows" should not happen in a prison setting because staff should know the patient's location and ensure that the appointment or treatment is completed, or require the patient to refuse the appointment or treatment, including signing a refusal of treatment form.

this patient is at increased risk of heart attack, stroke and kidney disease due to the lack of monitoring and treatment of his poorly controlled hypertension.

- This 49-year-old man arrived at EMCF in 2009 and transferred to MSP on June 22, 2016.[39] His medical history includes asthma, COPD with oxygen dependency, acute respiratory failure, paranoid schizophrenia and major depressive disorder. On October 3, 2015, the patient was hospitalized for respiratory failure. On November 22, 2015, he was scheduled for a chronic disease appointment but this did not occur. On December 6, 2015, the NP saw the patient for chronic disease management, during which time the patient presented with shortness of breath with exertion and wheezing. The nurse practitioner noted the patient's hospitalization in October for respiratory failure. The NP ordered antibiotics and steroids for the patient, and assessed him as having severe COPD in poor control, ordering a follow-up visit in 3 months. This is not an appropriate follow-up interval given the patient's poorly controlled COPD and previous hospitalization. The following week, the patient was readmitted to the hospital for poorly controlled COPD.

- This 66-year-old arrived at EMCF in 2011.[40] His medical history includes diabetes, hyperlipidemia, latent tuberculosis infection and schizophrenia. On July 12, 2015, a NP saw the patient for follow-up. The NP documented that the patient had a past medical history of asthma, hepatitis and seizure disorder but the patient did not have these conditions and it appears that the NP documented them on the wrong patient's health record. As a result the NP did not evaluate the chronic diseases the patient was known to have. The NP planned to order labs and see the patient in 3 months. This appointment did not occur for 5.5 months. Thus the patient was not medically evaluated for his chronic diseases at the July 2015 visit and then was not seem timely for his follow-up visit.

- This 32-year-old man transferred to EMCF on May 9, 2016.[41] His medical history includes hypertension, chest pain, hepatitis C infection[42] and bipolar disorder. Labs taken prior to his arrival at EMCF, on May, 31 2013, showed that the patient had a positive hepatitis C antibody test and his liver enzymes were elevated, indicating that he may have chronic hepatitis C infection. Untreated, hepatitis C infection may progress to cirrhosis and liver cancer. However, no further evaluation was performed. On June 24, 2016, a NP saw the patient for chronic disease management. There was no assessment of the patient's hypertension or hepatitis C infection. The NP planned to order labs and see the patient in 3

[39] Patient #2.
[40] Patient #4.
[41] Patient #6.
[42] Hepatitis C infection is caused by a virus. Once infected, about 15-25% of patients resolve their infection without any treatment and no longer have it. About 75-85% of patients will develop chronic infection and are at risk of inflammation of the liver that may lead to cirrhosis and/or liver cancer from which they may die, but which may be treated and in many cases cured. To confirm a diagnosis of chronic infection, medical providers should order a hepatitis C viral load test, which was not done for this patient, and therefore, it was not known whether he would benefit from treatment.

months. At the time of my review, the patient had not been evaluated to determine if he has chronic hepatitis C infection, and if so, to determine the proper course of treatment.

- This 38-year-old man transferred to EMCF in early 2011.[43] His medical history included hypertension, diabetes, glaucoma and psychotic disorder. On July 10, 2015, labs showed that the patient's diabetes was poorly controlled (HbA1c=12.3%, goal=≤7%). A provider did not see the patient following this report to adjust his diabetes medication. Three months later, on October 21, 2015, the patient's diabetes was again poorly controlled (HbA1c=12.6%). Four days later, a NP saw the patient for follow-up. The NP adjusted the patient's insulin and ordered follow-up in 3 months. This was not an appropriate time interval for follow-up given the patient's poor diabetes control. The patient's triglycerides (TG), a form of cholesterol, were very high (TG=331, normal≤150), increasing a risk of pancreatitis.[44] On January 26, 2016, a different NP saw the same patient for follow-up. She did not address the patient's high triglycerides (hypertriglyceridemia). She noted the patient's diabetes to be in poor control, but did not change the patients' treatment plan. She planned to get labs and see the patient in 3 months. This was not appropriate given the patient's poor disease control. On February 2, 2016, labs showed the patient's diabetes had worsened (HbA1c=12.8%). The patient was not timely seen after this abnormal lab report. In addition, April 2016 MARs show that the patient did not receive his glaucoma medications, increasing his risk of vision loss, and that he also missed many morning doses of his chronic disease medications for treatment of diabetes, high blood pressure, and high triglycerides (e.g., insulin, Lisinopril, metformin and gemfibrozil). On April 25, 2016, a NP saw the patient for follow-up. Again, the NP noted the patient's diabetes was poorly controlled, but did not change the treatment plan and did not address his hypertriglyceridemia. On April 27, 2016, labs again showed the patient had significant hypertriglyceridemia and poorly controlled diabetes (TG=326, and HbA1c=12.0%). As of July 15, 2016, the patient had not been seen for chronic disease follow-up. This patient had not had timely or appropriate treatment for his poorly controlled diabetes, hypertension, and hypertriglyceridemia and has not received medications for his glaucoma. This increases his risk of diabetes complications, including diabetic ketoacidosis[45], heart attack, kidney disease and vision loss.

In summary, EMCF medical providers do not monitor and treat chronic disease patients in accordance with their disease control, nor do they adhere to nationally recognized guidelines for early detection and prevention of complications (e.g., eye and foot examinations for diabetics). Patients experience disruptions in medications that contribute to worsening disease control and are not timely counseled for medication non-adherence. At EMCF, chronic disease

[43] Patient #13.
[44] Pancreatitis is an inflammation of the pancreas that can be caused by alcohol, medications, or very high triglycerides often resulting in hospitalization. Severe cases can cause death.
[45] Diabetic ketoacidosis is a result of poorly controlled diabetes with very high blood sugars and can result in coma and death.

patients are at increased risk for complications and harm from their poorly controlled chronic diseases.

Urgent Care and Hospitalizations

Adequate care for patients with urgent complaints and hospitalizations requires that patients with urgent conditions have timely access to a medical provider who can diagnose and treat their conditions. If the patient requires transport to a hospital, the transport vehicle should be adequately equipped and supplied to treat the patient (e.g. oxygen, intravenous fluids) should the patient's condition deteriorate during transport to the hospital. Following hospitalization, the facility should ensure that hospitalization records and discharge recommendations are timely reviewed and implemented. If the facility physician does not order hospital discharge recommendations, the physician should document the clinical rationale for the departure and monitor the patient to ensure that the patient's condition has improved.

To review access to urgent care, I selected records from the Centurion emergency room (ER) and hospital admissions logs, and reviewed each record for the timeliness and appropriateness of emergency response, the timely review of hospital reports and the timely follow-up with hospitalized patients. For patients with exacerbations of their chronic diseases, I reviewed the record to determine whether providers timely monitored and treated patients in accordance with their disease control.

My review showed that EMCF patients did not receive timely and appropriate care for their urgent medical conditions, resulting in preventable hospitalizations. My review also showed that the physician did not provide timely follow-up for patients returning from the hospital and frequently did not address hospital discharge recommendations. In some cases, this resulted in readmission of patients to the hospital. In some cases patients are transported by van instead of ambulance, which is frequently not medically appropriate for patients with urgent conditions.

The following are examples of these issues:

- This 49-year-old man has a history of severe COPD with oxygen dependency, acute respiratory failure, anorexia, weight loss, paranoid schizophrenia and major depressive disorder.[46] On October 31, 2015, the patient presented urgently with severe difficulty breathing, shortness of breath and audible wheezing. The nurse did not document the onset and duration of the patient's symptoms. His oxygen saturation (Sp02) was dangerously low (SpO2=80%). The nurse gave him a breathing treatment with nebulized albuterol and his oxygen saturation increased to 84%, but overall remained low and he continued to experiencing difficulty breathing, with audible wheezing. The nurse contacted the on-call provider and the patient was sent to the Anderson Regional Medical Center's emergency department where he was admitted and treated for severe COPD and

[46] Patient #2.

respiratory failure. On November 2, 2015, he was discharged back to EMCF and was prescribed a steroid inhaler (Symbicort) and antibiotics. The physician did not see the patient upon his return to EMCF and did not order clinical follow-up for the patient. The patient did not receive prescribed medications until November 4, 2015, more than two full days after his release from the hospital. On December 14, 2015, the pharmacist contacted the physician to clarify the Symbicort order. The pharmacist noted that it was usually dosed 2 puffs twice daily (and the discharge orders required the same) but the physician had written the order for 1 puff twice daily. The physician advised the pharmacist to give the medication as he ordered without documenting the rationale for his departure from the hospital's recommendations. As a result, the patient was given one puff twice a day, less than the dose recommended by the hospital physician and pharmacist. On December 20, 2015, medical staff saw the same patient urgently for incoherence and low oxygen saturation of 75%. Staff treated him for ingestion of an unknown drug with activated charcoal, but did not send him to an off-site emergency department. The patient should have been sent to the emergency department for his altered level of consciousness (i.e. incoherence).

- On February 2, 2016 at 12:45 am, a RN saw the same patient urgently for extreme difficulty breathing; as the patient noted, he "Can't breathe deep down." The RN did not perform an assessment, including listening to the patient's lungs. The patient's oxygen saturation was dangerously low (SpO2=79%). The nurse gave the patient two albuterol treatments and the patient's oxygen saturation increased slightly to 84%. The nurse placed the inmate on oxygen. The nurse notified the physician of the patient's status and treatments rendered. At about 1:30 am, the patient was transported to Rush Hospital. A few hours later, at about 4:00 am, the hospital discharged the patient back to EMCF with a prescription for oral steroids. Later that day, the patient again presented to medical staff with shortness of breath and oxygen saturation of 61%. The nurse performed no other assessment, including describing the patient's general condition, appearance, color, listening to the patient's lungs or taking vital signs. The nurse administered two albuterol treatments and the patient's oxygen saturation increased to 94%. Over the course of the following week, neither the physician nor NP saw the patient for follow-up. On Sunday, February 14, 2016, the patient again presented urgently to the nurse, stating that he could not catch his breath. The nurse did not measure the patient's vital signs or listen to his lungs, but noted his oxygen saturation as 85%. The nurse gave the patient an albuterol treatment and his oxygen saturation increased to 93%. The RN called the NP who ordered steroids. The following week, neither the physician nor NP saw the patient for follow-up. On February 17, 2016, the patient was sent to the emergency department with shortness of breath. The patient was admitted and treated for acute COPD exacerbation. Nursing staff notified the physician after the fact that the patient was sent out by ambulance. On February 19, 2016, the patient returned to EMCF and was admitted to the infirmary, but the physician did not see the patient for five days. On May 3, 2016, the patient again presented in respiratory distress and was sent to the emergency department in acute respiratory failure. And a month later, on June 16, 2016, the patient was again admitted to Rush Hospital. The hospital physician noted that this was his third hospitalization for acute exacerbation of

COPD and that it had previously been recommended for the patient to receive continuous supplemental oxygen (i.e. Portable oxygen tank). The patient was thereafter transferred to MSP.

This patient was hospitalized repeatedly for acute COPD exacerbations but neither a physician nor NP saw the patient timely after each hospitalization. Nor did the physician see the patient timely after he was placed in the infirmary. As a result, the patient's condition continued to worsen, likely resulting in preventable hospitalizations.

- This 40-year-old man arrived at EMCF in 2011.[47] On January 28, 2016, the patient was sent to Anderson Regional Medical Center with a two-day history of a very large abscess on his left upper lip extending into the labial fold of his nose, cheek and forehead. The hospital physician noted facial swelling starting from the lip, which was about 4 times larger than normal size. The diagnosis was left upper lip cellulitis and abscess. The patient was admitted and underwent surgical incision and drainage of his lip and facial area. He was given IV antibiotics and then started on oral and topical antibiotics. He was to have follow-up in two weeks with the ENT specialist. On January 31, 2016, a RN documented that the patient returned from the hospital and had a wound to his upper lip with sutures. He had a fever of 101.1 F (Fahrenheit). The nurse noted that the patient was to return to see a specialist in two weeks. The patient was admitted to the infirmary, to stay until the follow-up. On February 1 and 2, 2016, the physician did not see the patient while he was in the infirmary. On February 3, 2016, the physician saw the patient and discharged him from the infirmary. The physician did not document review of the hospital recommendations for the patient, including the recommendation of a two week follow-up, however the patient did receive the follow-up appointment with the ENT, who noted that the institution failed to order topical antibiotics that he recommended. The ENT reordered the medication.

Specialty Services

Specialty services are provided to patients that require specialized medical care beyond what is provided by a primary care provider (e.g., physician, nurse practitioner). Services include those such as cardiology, ophthalmology and orthopedics. Many patients requiring specialty services tend to be of higher medical acuity and are at risk of harm if access to specialty care is delayed, or providers do not timely address and implement specialist recommendations.

My review of specialty services was limited to specialty services found in records of patients with chronic diseases. In reviewing specialty services, I determined whether the service occurred timely following the determination that the service was needed. I also determined whether a consultant report was received following performance of the service and whether a physician timely reviewed the report and met with the patient to discuss the findings and recommendations. I also assessed whether the physician developed a treatment plan and

[47] Patient #5.

monitored the patient to determine if, following implementation of the treatment plan, the desired clinical outcome was achieved. My review showed that none of these steps reliably take place at EMCF and that patients are at risk of harm as a result of both these failings as well as the physician's failure to implement consultant recommendations.

The following are examples of the above issues:

- This 46-year old man transferred to EMCF on May 12, 2016.[48] On February 12, 2016, while the patient was at his prior facility, he suffered facial trauma and was sent to the hospital, where he presented with a 5 centimeter facial laceration and mandibular fracture. His jaw was wired shut and he was housed in the infirmary on clear liquids. During the course of his infirmary stay at the prior facility, his wires came out of the brackets and apparently were not replaced.[49] Upon his arrival at EMCF, the nurse performing medical screening did not document that the patient required follow-up with oral surgery and did not refer the patient to the physician. Despite the lack of documentation of referral, on May 20, 2016, an oral surgeon saw the patient and noted that he was doing well and that he planned to see the patient again in 3 weeks for arch bar removal. A nurse saw the patient upon return from the outside medical appointment, but there is no documentation that the physician saw the patient or requested follow-up with the oral surgeon. The patient did not receive the requested follow-up, therefore it is unclear if and how the arch bar was removed, and if removed, whether the patient received sedation to avoid preventable pain.

- This 38-year-old man transferred to EMCF in early 2011.[50] His medical history includes glaucoma. This patient has had multiple ophthalmology consults for his glaucoma, but ophthalmology reports are not in his record. The physician has never seen the patient following ophthalmology consults, and the patient has not received continuity of his glaucoma medications. This patient is at risk of vision loss due to untreated glaucoma.

- This 50-year-old man's medical history includes diabetes, diabetic retinopathy, cataracts and bipolar disorder.[51] On June 9, 2015, an outside ophthalmologist saw the patient and ordered antibiotics (Ciprofloxacin) for senile cataract. There is no accompanying report of the ophthalmologists' findings and recommendations. On March 2, 2016, EMCF optometry saw the patient and noted his visual acuity was poor (20/200 both eyes) with no improvement with refraction (i.e., different lenses). EMCF optometry referred the patient to the outside ophthalmologist but, as of July 15, 2016, this had not

[48] Patient #1.
[49] Following a fracture jaw, the oral surgeon may insert an arch bar and wires to provide stability while the jaw fracture heals. During this time the patient is unable to open his mouth and must eat a liquid diet. If the arch bar and wires are removed prematurely, the jaw may not heal properly. After the jaw fracture remains stable, the wires and arch bar are removed under sedation.
[50] Patient #13.
[51] Patient #12.

taken place. The physician did not monitor the patient to ensure that appointments took place as scheduled.

These cases show that EMCF does not have a reliable system for timely obtaining and reviewing consultant reports, and the physician does not document review and ordering of consultant recommendations. In some cases, medical follow-up recommended by the consultant does not take place. The lack of a system for timely review of consultant recommendations creates a risk of harm to patients from failure to implement follow-up medical care.

Infirmary Care

Infirmary care is a level of care for patients that are acutely ill due to medical or mental health conditions, but do not require hospitalization. It is also provided to patients who need temporary assistance with activities of daily living (e.g., eating, bathing, etc.) that cannot be provided in general population. At EMCF, the infirmary is also used for patients placed on suicide watch who require close monitoring. Infirmary patients are often medically fragile, and require consistent monitoring and medical/mental health evaluations during the course of their stay to determine if their condition is improving or worsening and if changes in treatment plans are required. In order to provide timely and appropriate care to patients, it is important that a sufficient number of infirmary beds are available to treat all patients requiring infirmary care.

To evaluate this area, I toured the medical observation and infirmary unit and reviewed records of patients placed in the infirmary. My review showed that EMCF has an insufficient number of infirmary beds to accommodate patients with acute medical and mental health conditions. This has resulted in acutely ill patients being sent back to their housing unit and not receiving timely monitoring and treatment for their serious medical conditions. As a result, patient's medical conditions deteriorated and required admission to the hospital. I also found that the EMCF physician did not perform daily rounds, as required by Centurion policy and the MDOC/Centurion Health Services Contract. In addition, the physician's notes are devoid of any meaningful clinical information and do not address the patient's serious medical conditions, including acute medical conditions (e.g., acute renal failure) and chronic diseases. Nurses' assessments were also inadequate and did not reflect monitoring of the conditions for which the patient was admitted to the infirmary.

The EMCF infirmary has 10 beds, with 9 beds allocated for mental health patients and 1 bed allocated for a medical patient. This is an insufficient number of beds for the size and type of population being served at EMCF, and Mr. Little, EMCF's Health Services Administrator, in fact stated that the infirmary maintains a high occupancy rate. As a result of high occupancy, overflow infirmary patients are placed in a non-infirmary room in the medical area that does not have a bed, toilet or running water. The lights are on 24 hours a day, interfering with patients' normal sleep patterns. Thus, this overflow room lacks the most basic necessities for providing health care to an acutely ill patient.

In addition, overflow infirmary patients are placed in cells in the Intake Unit. This is a non-medical area that is not staffed with correctional officers or health care staff. Therefore patients are not within sight or sound of appropriate staff at all times, as required by Centurion policy and NCCHC Standards.[52] These cells also lack a call system, and patients do not have the ability to notify staff in the event of an emergency. Health care staff also do not perform required rounds for patients housed in the Intake Unit; the area was poorly maintained and unsanitary; and it lacked beds.[53]

For those patients that do stay in the infirmary, the physical plant is inadequate. Some rooms have beds with rails that patients at risk of suicide could use to hang themselves[54] – and, notably, there was a recent suicide[55] in the infirmary. Infirmary rooms are dark and dirty.[56] There is no functional call system for patients to contact staff if they are in distress. And, as noted above, correctional officers are to continuously monitor patients via installed cameras; however due to obscured windows, cameras do not show the interior of the infirmary rooms or the condition of the patients.

Also, as noted in my last report[57], patients with serious medical conditions are housed in the infirmary without the physician formally admitting the patient with accompanying medical orders. Instead, patients are placed in "Sheltered Housing"[58] status, often with no medical orders to monitor and treat the patient. This is not compliant with Centurion policies and procedures or the MDOC Centurion Contract. Nor does a medical provider make daily rounds, including weekends, as required by the MDOC/Centurion contract. The policy and contract requirements are necessary to ensure that acutely ill patients receive timely monitoring and treatment for their serious medical conditions; this lack of monitoring therefore poses a significant risk to patient health.

And, when medical rounds are completed by the physician, he does not document an adequate clinical evaluation of the patient, even for patients with chronic diseases or following hospitalization. A clinical evaluation consists of collecting subjective (symptoms) and objective data (physical examination findings) and noting labs that are pertinent to the patient's condition. It also includes making an assessment, or diagnosing the patient. However, my review showed that in many cases, there is no indication that the physician even saw the patient in the infirmary, much less performed a clinical evaluation.

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[52] Infirmary Care. G-03. November 2, 2015.

[53] Patient #19 was housed in the Intake Area from July 6 through 12, 2016. On July 12, when we performed our medical tour, health care staff had not made rounds on the patient on July 8, 9, or 10.

[54] Infirmary cell 521.

[55] Patient #21.

[56] During our tour, staff were performing repairs to an infirmary room in which a mental health patient had started a fire.

[57] EMCF Report. Madeleine LaMarre MN, FNP-BC. June 16, 2014. Page 33.

[58] Sheltered housing is a term used for patients who purportedly do not have an acute medical condition but require only assistance with activities of daily living.

The case described below is an egregious case of poor medical treatment in the infirmary. In this case, a severely mentally ill and diabetic patient became catatonic and was unable to comply with his treatment for diabetes (e.g. insulin injections). Due to his catatonic state, he also did not eat meals or drink fluids for a 10-day period. His resulting poorly controlled diabetes and dehydration led to acute renal failure. Yet, during this time, the patient never received medical evaluation and treatment by the physician for his diabetes – even after the patient's acute renal failure was known to the physician, a shocking lapse in care. The details below are provided to highlight this failing, and also to show the repeated examples in which the nurses exceeded their scope of practice by not administering insulin to the patient as ordered, and not notifying the doctor of the reasons insulin was withheld. This case also demonstrates the lack of availability of an infirmary bed when the patient's mental health and medical condition had deteriorated; the lack of timely mental health treatment caused by lack of availability of psychotropic medications; and the inappropriate transport of the patient to the hospital in a van instead of an ambulance:

- This 62-year-old man arrived at EMCF in 2009 and transferred to MSP on April 28, 2016.[59] His medical history includes diabetes, hypertension, hypothyroidism, asthma, and severe schizophrenia, as well as a history of catatonic episodes. On December 2, 2015, the mental health NP documented that the patient was referred to her by nursing staff for not coming to medication administration to receive medications, including insulin, and because the patient was not eating well. The NP admitted the patient to the infirmary. The physician did not make daily infirmary rounds as required by policy. A full five days later, on December 7, 2015, the physician documented an infirmary progress note as follows:[60]

  > S: No acute distress noted. Offender has diagnosis of IDDM (insulin dependent diabetes) and HTN (hypertension), hypothyroid and asthma.
  > O: Very cooperative with staff. Able to follow simple commanders. Vital signs taken and noted.
  > A: None
  > P: Will continue to monitor.

  Although the patient had diabetes, hypertension, hypothyroidism, and asthma, and had been refusing insulin and blood sugar checks, the physician did not perform any medical evaluation of the patient (i.e. interviewing the patient about diabetes symptoms, noting whether his vital signs were normal or abnormal, examining the patient, ordering labs,

[59] Patient #3.

[60] Physicians and nurses typically use the SOAP format to document clinical notes. S is for subjective information, which includes the patient's onset of symptoms, medical history and review of systems (e.g. chest pain, shortness of breath, etc.). O is for objective information which includes physical examination findings and laboratory or diagnostic test results. A is for Assessment which is the physician's medical diagnosis, and P is for Plan which includes medications, labs and follow-up appointments.

etc.). On December 9, 2015 the patient's mental health had improved and he was discharged from the infirmary back to his housing unit.

On December 20, 2015, staff documented that the patient began to refuse daily blood sugar checks and insulin. On December 21, 2015 at 12:00 am, a RN responded to a code blue at the patient's location. She documented that she found the patient on his bunk awake, but unresponsive. She attempted to rouse the inmate verbally and with mild stimuli. After performing a blood sugar check, the nurse rubbed the patient's shoulders and the patient became combative and attempted to strike nurses and officers.[61] No other action was documented, including notifying the physician to admit the patient to the infirmary or to send the patient to an outside hospital. This should have been done, as the patient was not responding to the nurse and became combative, which could have been related to a serious medical or mental health condition.

On December 26, 2015 at 5:00 pm, a nurse responded to the patient's cell at the time the patient was to receive a blood sugar check. The patient's medical record states that, "The patient was nonresponsive to myself and officers. Did not give insulin due to patient not eating or drinking." The LPN noted that the patient's respirations were even and unlabored. The LPN did not take vital signs but planned to "continue to monitor." The LPN reported the patient's condition to the charge nurse but not the physician.

On December 26 and 27, 2015, LPNs did not give the patient his insulin, due to his not eating and drinking. However, the nurse did not notify the physician that the patient was not eating or drinking and that she was withholding his insulin. This withholding of medication without a physician order exceeded the LPN's scope of practice.

On December 27, 2015 at 9:51 pm, a RN documented an extensive note noting that the patient was refusing meals and not coming for blood sugar checks and insulin. The Director of Nurses requested that the nurse call a Lieutenant to ask the Warden if the patient could be placed in the Intake Unit, since an officer was already there with another inmate. The nurse documented that the Warden refused this request. The RN contacted the Director of Nurses and they discussed that the Intake Unit did not have adequate lighting and no bed, and a decision was made for nurses to observe the patient every 2 hours, presumably in his housing unit, until the following day, when the patient could be seen by the doctor and mental health. However, nurses did not monitor the patient every 2 hours as planned.

On December 28, 2015 at 8:00 pm, an RN documented that Dr. Nagel, a psychiatrist, admitted the patient to the infirmary. The patient was curled up in a fetal position, and permitted a nurse to take vital signs, but was otherwise uncooperative and combative.

[61] The patient's blood sugar was 140, which was within normal limits, and therefore changes in his mental status were not due to low blood sugar.

The nurse did not notify the physician to obtain medical orders for monitoring of his diabetes or other medical conditions. The same day, Dr. Nagel gave orders to add lorazepam to treat the patient's severe mental health condition. However, two days later, as of December 30, 2015 at 4:00 pm, the medication had not arrived and been administered to the patient. This was not timely given the severity of his condition.

On December 29, 2015 at 6:49 am, Dr. Abangan documented:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, hypothyroidism.
> O: Refused morning medical visit and vital signs. UNABLE TO GET VITAL SIGNS.
> A: None.
> P: Will continue to monitor.

Despite the patient refusing insulin for approximately 10 days, the physician did not document any clinical evaluation of the patient or order labs to evaluate his medical conditions.

On December 30, 2015 at 6:00 am, the nurse documented that the patient stood up, staggered and fell on the floor. The nurse assisted him back to bed.

On December 30, 2015 at 6:51 am, Dr. Abangan documented:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, hypothyroidism.
> O: Very cooperative with staff. Morning visit and vitals done. BP=88/56 mm Hg, pulse =76 respirations=16/minute and afebrile (no fever).
> P: Will continue to monitor.

The physician did not reference the fact that the patient was catatonic, had been refusing meals and medications, including insulin and was hypotensive (low blood pressure). He did not perform any clinical examination of the patient whatsoever.

On Thursday December 30, 2015 at 11:50 am, labs showed the patient's diabetes was out of control and he was in acute renal failure (likely due to lack of fluids).

On December 30, 2015 at 3:55 pm, the mental health NP documented that Ativan and Risperdal ordered for the patient to treat his psychosis and combative behavior on December 28, 2015 had not arrived yet from the pharmacy. This resulted in the patient's persistent psychosis and inability to cooperate with his medical treatment plan. The fact that EMCF is a mental health treatment facility, but did not have commonly used psychotropic medications available to timely treat this severely mentally disordered patient reflects a serious inadequacy in access to care.

On December 30, 2015 at 6:00 pm, the patient's diabetes was out of control (blood sugar=542, normal random=≤150). The nurse did not perform an assessment for

symptoms of diabetic ketoacidosis (DKA)[62] or take the patient's vital signs. The nurse gave the patient 40 units of Lantus and 14 units per sliding scale. At 9:10 pm, the patient's blood sugar was still significantly elevated (492). The nurse did not perform any assessment, but notified the physician, who ordered that the patient be transported to the emergency department *per van instead of ambulance*. This was inappropriate as the patient was mentally ill and had an acute medical condition, and if his condition had deteriorated during transport, a correctional van would not have had the medical staff or equipment to provide emergency medical treatment. On December 31, 2015 at 12:26 am, the patient returned from the hospital after "refusing"[63] to get out of the van.

On December 31, 2015 at 5:33 pm, the nurse documented notifying Dr. Abangan of the December 30, 2015 lab results showing that the patient was in acute renal failure. The nurse did not document receiving any medical orders from the physician.

The patient's condition continued to deteriorate. On Sunday, January 2, 2016, a nurse documented that the inmate did not take his medication because she scared him when she waked him. She documented: "He is deteriorating mentally. Not Stable. Continue to Monitor." *There is no documentation that the nurse notified mental health or the physician, and the physician did not see the patient after he allegedly refused to get out of the van.*

On January 4, 2016, Dr. Abangan signed the lab report showing the patient was in acute renal failure. He documented: "IM BUN and Creatinine was up. He was sent to the hospital and refused treatment." *The physician did not document any plan to treat the patient's acute renal failure.* The physician did not acknowledge that the patient was severely mentally ill, catatonic and almost certainly did not have the capacity to refuse medical treatment when he was sent to the hospital. Had the patient been sent by ambulance instead of a correctional van, the patient would not have been put in the position of "refusing to get out of the van."

On January 5, 2016, at 7:53 am Dr. Abangan documented:

> S: No acute distress noted. Has medical diagnosis of IDDM, HTN and hypothyroidism.
> O: Very cooperative with staff. Vital signs taken. BP=131/76 mmHg, pulse=119/minute respirations=18/minute and 97.7 F.
> A: Encourage patient to push fluids.
> P: Will continue to monitor.

[62] Diabetic ketoacidosis is a life-threatening complication of poorly controlled diabetes.

[63] Although staff documented that the patient "refused" to get out of the van, this patient was catatonic and acutely ill from diabetes and acute renal failure. It is likely that the patient did not have the mental capacity to refuse and his condition warranted immediate medical treatment.

Again, the physician did not reference the December 30, 2015 labs showing the patient was in acute renal failure. He did not address the patient's abnormally rapid pulse (119/minute) or assess any of his other medical conditions.

On January 6, 2016 at 7:28 am, Dr. Abangan saw the patient and documented:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism.
> O: Very cooperative with staff. Morning vital signs taken and medical visit done.
> BP=138/73 mm Hg, pulse =97 respirations=16/minute and 98.7.
> P: Will continue to monitor.

Again, the physician did not address the patient's renal failure, fluid intake or other chronic diseases.

On January 6, 2016, the mental health NP documented that she saw the patient with Dr. Nagel and they agreed that his catatonic symptoms had resolved. Dr. Nagel did not document a note. They decided to discharge him for psychiatric purposes and turn his case over to medical for evaluation for discharge.

On January 7, 2016 at 7:57 am, Dr. Abangan saw the patient and documented the following note:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism.
> O: Very cooperative with staff. Morning visit and vital signs done.
> BP=144/77 mm Hg, pulse =101 respirations=18/minute and 97.8.
> P: Will continue to monitor.

That same day, the patient's labs showed that his acute renal failure had resolved, but the physician did not review the report for four days, until January 11, 2016.

On January 28, 2016 at 4:28 am, a nurse notified Dr. Abangan that the patient was unresponsive with low oxygen saturation (Sp02=86%) and severely elevated blood pressure (BP=189/99 mm Hg). The patient reported not eating. The nurse gave the patient oxygen at 4L/minute increasing to 99% but when the oxygen was removed, his oxygen saturation declined to 86%. The patient was sent out to the emergency department via ambulance.

On January 28, 2016 at 4:28 am[64], the nurse documented that the patient returned from offsite and was feeling better. I find no hospital report in the record, but discharge instructions were included relating to schizophrenia and prescriptions for Ativan and Benadryl.

On January 28, 2016 at 7:51 am, Dr. Abangan saw the patient and documented the following note:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism.
> O: Refused morning vital signs and visit. UNABLE TO GET VITAL SIGNS.
> A: Remain on Psych observation.
> P: Will continue to monitor.

The physician did not acknowledge the patient's abnormal oxygen saturation and vital signs prior to being sent to the hospital. He did not document any subjective information, including a review of systems or discussion with the patient about cooperating with health care staff to obtain vital signs. He performed no physical examination. He did not order any labs or review hospital findings and discharge recommendations.

On March 17, 2016 at 7:00 pm, the patient was admitted to the infirmary for being unresponsive and not taking his medication, food or insulin. His vital signs were significantly abnormal (BP=209/119 mm Hg, pulse=119/minute, respirations=18 and afebrile). At 10:30 pm, repeat vital signs showed his blood pressure was severely elevated (BP=180/105 mm Hg). There is no documentation that a nurse notified the physician regarding the patient's abnormal vital signs, creating a serious risk of harm for this patient due to lack of diagnosis and treatment for his abnormal vital signs.

On March 18, 2016, the mental health NP saw the patient and noted that he was catatonic and not eating or coming to medical for blood sugar checks and insulin. The NP ordered Ativan 1 mg IM daily for 14 days. It was given, and the patient started talking and eating again.

On March 21, 2016 at 8:37 am, Dr. Abangan saw the patient and documented the following note:

[64] In some cases, nurses documentation of the date and time of certain events does not appear to have been contemporaneous, but after the fact. Therefore some dates and times in the records are conflicting and may not reflect the actual time when care was provided. For example, it appears that the nurse documented sending the patient out to the hospital and the patient's return from the hospital at the same time, January 28, 2016 at 4:28 am. The nurse should document events contemporaneously in the record.

S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism, severely catatonic, been readmitted several times for catatonia.
O: Patient refused morning vital signs and MD visit. UNABLE TO GET VITAL SIGNS.
A: Patient remains of Psych/med obs[ervation].
P: Will continue to monitor.

The physician did not address the patient's poorly controlled hypertension, noted 4 days, prior or conduct any physical examination of any kind.

In summary, as noted above, there were multiple deficiencies in nursing and medical care during each of the patient's three infirmary admissions, during which time the physician did not perform any meaningful clinical evaluation of the patient. From a medical perspective, the care he received amounted to no care at all.

- This 32-year-old man transferred to EMCF on May 9, 2016.[65] He was transferred to EMCF because of psychosis, poor hygiene and refusal to take medications, and his medical history includes hypertension, chest pain, hepatitis C infection and bipolar disorder.

  Upon his arrival at EMCF at 7 am, the patient was admitted directly to the infirmary. A nurse did not perform medical screening immediately upon arrival, which should have been done to identify all medical conditions and medications requiring follow-up care. Approximately 10 hours later, at 5:26 pm, a RN performed intake screening noting that the patient complained of dental issues, but was confused with rambling speech and poor hygiene. His vital signs were stable. The receiving screening nurse did not document a plan. The mental health NP ordered medications (e.g., propranolol, Zyprexa and Benztropine), and later that same day, the psychiatrist adjusted his medications

  On May 16, 2016, Dr. Abangan wrote an infirmary progress note as follows:

  S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
  O: Cooperative with staff, morning assessment and vital signs taken.
  Temp=98, pulse=77, Resp=16, BP=128/88 mm Hg.
  A: Remain on medical in psych observation.
  P: Will continue to monitor.

  Although the patient had a history of hypertension, the physician did not address a treatment plan for hypertension, including medications, nor did he order labs typically ordered for hypertensive patients (e.g. serum chemistry, etc.).

[65] Patient #6.

On May 17, 2016, Dr. Abangan wrote an infirmary progress note as follows:

> S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
> O: Unable to obtain vitals. Refused morning assessment. UNABLE TO GET VITAL SIGNS.
> A: Remain on medical in psych observation.
> P: Will continue to monitor.

The same day, Dr. Nagel added propranolol to the patient's medication regimen. Although, this medication has been used in the past to treat high blood pressure, it is unclear whether the psychiatrist ordered the medication for mental health or medical reasons. This is significant, both because psychiatrists do not typically treat patients for high blood pressure and propranolol is no longer used as a first line treatment for high blood pressure.

Thereafter, on May 23, 2016, Dr. Abangan wrote an infirmary progress note as follows:

> S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
> O: Unable to obtain vitals. Refused morning assessment. UNABLE TO GET VITAL SIGNS.
> A: Remain on medical in psych observation.
> P: Will continue to monitor.

Dr. Abangan wrote the exact same note for the subsequent three days, thus performing no medical evaluation of the patient's chronic diseases.

In summary, although the patient was admitted to the infirmary for psychiatric reasons, the patient had serious medical conditions, including hypertension that the physician failed to assess in even the most basic fashion, such as measuring vital signs, including blood pressure.

- Finally, I have included details of yet another case that shows the lack of timely physician evaluation and treatment for a patient with severe respiratory disease that required frequent hospitalizations. This 49-year-old man arrived at EMCF in 2009 and transferred to MSP on June 22, 2016.[66] His medical history includes asthma, severe COPD with oxygen dependency, acute respiratory failure, paranoid schizophrenia and major depressive disorder.

  On February 17, 2016, the patient was sent to the emergency department with shortness of breath. The patient was admitted to the hospital and treated for acute COPD exacerbation. On February 17, 2016, the hospital discharged the patient and he

[66] Patient #2.

was housed in the infirmary at EMCF in "sheltered housing status." Given the patient's recent hospitalization, abnormal vital signs and low oxygen saturation, the patient exceeded the criteria for sheltered housing and should have been formally admitted to the infirmary, which would have required medical orders including the frequency of medical monitoring, labs, treatments and criteria for notifying the physician should the patient's condition worsen. However, the nurse did not notify a provider to obtain medical orders. Later that night, a RN assessed the patient. His oxygen saturation was low (SpO2 sat=90%), but the nurse did not listen to the patient's lungs or measure his peak expiratory flow rate, which should have occurred for a patient with severe lung disease. Over the next 24 hours, other nurses performed similar, inadequate assessments of the patient, often documenting that the nurse would "Continue to monitor." On February 22, 2016, the patient was discharged from sheltered housing without being examined by the physician. Rather, he was discharged back to his housing unit per order of Mr. Little, EMCF's Health Services Administrator. It is not appropriate for an administrator, who has not medically evaluated the patient, to make a clinical decision to discharge the patient from the infirmary. This patient had an exacerbation of his severe COPD and was not medically evaluated or appropriately monitored while he was in the infirmary.

In summary, patients placed in the infirmary do not receive timely and appropriate medical evaluation, treatment and monitoring. This pattern is systemic and creates a risk of serious harm to EMCF patients.

Access to Dental Care

To assess access to dental care, I interviewed Mr. Little, EMCF's Health Services Administrator, reviewed dental staffing, toured the dental unit, and reviewed health records to assess the timeliness of care for patients with dental pain and infection.

The first step in access to dental care is for nurses to initially assess patients' dental complaints during sick call encounters to determine the urgency of referral for dental treatment. For patients with severe pain and/or infection, the nurse should contact a dentist or medical provider to determine the need for immediate evaluation and treatment, or to receive orders for antibiotics and pain medication pending a dental appointment.

My review shows that these steps do not occur. Nurses do not consistently assess the urgency of a patient's MSR for dental pain or contact a medical or dental provider for antibiotics and analgesia while the patient is pending a dental referral. As a result, EMCF patients wait weeks and even months for dental treatment, resulting in a significant amount of preventable pain and suffering.

Mr. Little, EMCF's Health Services Administrator, reported that dental staffing for the facility is 40 hours per week, provided by three different dentists. However, as described by Mr. Little, the number of dentist hours provided by the three dentists did not add up to 40 per week.

Moreover, this is not compliant with the current MDOC/Centurion contract, which indicates that dental staffing will consist of a part-time dentist (i.e., 24 hours per week), plus a full time dental assistant, who cannot practice unless the dentist is present. Yet, there are no budgeted dental hygienists at EMCF to provide dental cleanings.[67] This is insufficient dental staffing for a facility with a capacity of more than 1300 inmates.

Evidence of insufficient access was demonstrated by the following examples:

- On November 3 and 4, 2015, a 69-year-old patient was listed on the dental sick call log for a broken tooth and dental pain.[68] A dentist did not see the patient. On April 6, 2016, the same patient submitted a MSR complaining of tooth ache and his face being extremely swollen. A nurse did not see the patient. On April 7, 2016, a staff person wrote that the patient had not been seen by the dentist the prior day, and the patient was rescheduled for April 14, 2016. On April 14, 2016, the dentist documented that the patient had a non-restorable tooth due to abscess. Consent for extraction of the tooth was obtained, but the dentist did not extract the tooth at that time. The dentist prescribed Ibuprofen but not antibiotics, despite noting the patient had a dental abscess, indicating the need for such treatment. At the time of my review in July 2016, the dentist had not seen the patient. This patient had suffered from dental pain and infection for more than six months.

- On October 29, 2015, a 28-year-old patient submitted a MSR complaining that the right sides of his teeth were aching, even when he brushed them, and that the pain was getting worse every day.[69] The MSR was received on October 30, 2015. On November 12, 2015, a dentist documented that the patient pointed to his front teeth, top and bottom, but that "The patient's teeth were too sensitive to examine today." The dentist gave the patient Peridex (antiseptic mouthwash) and Ibuprofen and rescheduled the patient. The dentist documented: "He is to return when not hurting." On December 28 and 29, 2015, the same patient was listed on the sick call log with dental pain. There is no documentation in the record that the patient was seen.

- On December 25, 2015, a nurse saw a different 28-year-old patient for dental pain that he rated 8 out of 10 in severity.[70] The patient had a hole in one of his teeth. The nurse gave the patient 5 days of Ibuprofen, but did not document a referral to dental and a dentist did not see him. Two months later, on February 25, 2016, dental saw the same patient and noted gross dental decay to one of his teeth. The dentist removed most of the decay and placed a temporary filling until the tooth could be extracted. The dentist did not order Ibuprofen or antibiotics. On February 27, 2016, another dentist extracted the tooth. Thus, this patient suffered with severe dental pain for two months before his tooth was extracted.

[67] A dental assistant assists the dentist while providing direct care to the patient. A dental hygienist performs tasks that are more advanced and independent, including taking dental x-rays and cleaning teeth.
[68] Patient #14.
[69] Patient #15.
[70] Patient #16.

- On January 17, 2016, yet another 28-year-old patient submitted a MSR complaining of a toothache.[71] On January 18, 2016, the form was received and a nurse saw the patient. The patient had a broken tooth on his lower left gum and wanted it pulled. The patient's pain was 4-5 out of 10 in severity. The nurse referred the patient to a dentist, but did not contact a provider for analgesia and/or antibiotics pending the appointment. The same day, the same patient submitted another MSR complaining of a toothache. On January 20, 2016, a nurse saw the patient. The nurse referred the patient to a dentist but did not contact a provider for analgesia and antibiotics. On January 28, 2016, dental saw the patient and extracted the tooth. The patient received no analgesia or antibiotics pending his dental appointment.

- On December 8, 2015, this 42-year-old patient was listed on the sick call log with dental pain.[72] A nurse did not see the patient to assess the severity of the pain, or to contact a provider or dentist for analgesia and antibiotics pending a dental appointment. On December 17, 2015, the dentist saw the patient. This patient did not receive timely treatment for his dental pain pending his appointment with the dentist.

These cases, as well as others below, show that patients do not have timely access to dental care at EMCF. As a result, patients suffer from preventable pain and infection, which in some cases, can be life-threatening.[73] The fact that one dentist told the patient to return when he "wasn't hurting" defies explanation. That, and the lack of antibiotic use and analgesia when EMCF dentists describe the presence of abscesses, also raises questions about the quality of dental care at EMCF and warrants peer review. Finally, as noted earlier in this report, dental equipment is in poor condition, cabinetry is falling apart, and the dental operatory is cluttered and dirty, presenting a serious risk of infection to EMCF patients and a threat to their health overall.

Health Records

The health record is a medical-legal document that records health care staff assessments and treatment provided to individual patients. The purpose is not only to document care provided to the patient, but also to facilitate communication among health care providers to ensure that care is coordinated, efficient and safe. It is important that the record is accurate and complete to prevent medical errors and harm to the patient. For example, it is important that following hospitalization, health records staff obtain a complete hospital report, as it may contain

[71] Patient #17
[72] Patient #18.
[73] Life-threatening dental infections include Ludwig's angina, an infection from the submandibular space below the floor of the mouth. The infection commonly arises from an infected second or third mandibular molar. It is an aggressive, rapidly spreading cellulitis with a potential for airway obstruction that requires rapid intervention to prevent asphyxia and aspiration pneumonia.

recommendations for follow-up tests, such as CT scans to rule out cancer, or cardiac stress tests to rule heart disease.

I evaluated the adequacy of health records by reviewing patient records to determine if documents were timely reviewed by a health care provider, accurately labeled and scanned into the record, and whether the health record was complete, including documentation of specialty services and hospital reports. My review showed that EMCF's health record system and EMCF's management of health documents is deficient and has led to inaccurate recordkeeping. Finally, the poor state of health records at EMCF also imperils patients' continuity of care, given the impact ability to review medical records has on a health care provider's ability to treat a patient.

MDOC has implemented an electronic medical record program (EMR), Centricity, throughout its correctional system, including at EMCF. Under the system, medical staff are to document all clinical encounters either in the EMR or on paper that is scanned into the EMR in a timely manner, so that the information is readily available to all staff caring for a patient. Timely scanning of health documents into the correct location decreases the risk of medical errors in future treatment.

However, the EMR's design and EMCF's staff's use of the EMR have resulted in dangerously deficient medical recordkeeping. For example, certain components in the EMR do not facilitate the provision of adequate care. Some provider notes (e.g., chronic disease) are prepopulated with information that is not current and, therefore, may lead to inappropriate treatment during subsequent encounters. Moreover, prepopulated disease definitions in the EMR are not current and may lead to inappropriate or ineffective treatment. For example, the definition of good HIV disease control is not current with contemporary medical standards, citing a viral load of less than 50,000 copies/ml, when current standards call for an undetectable viral load. This inaccurate definition may lead providers to fail to alter the treatment of patients with poorly controlled disease, rather than amend treatment to improve disease control. In addition, the EMR template instructions for patients with poorly controlled hypertension are to admit patients to the infirmary or perform daily blood pressure monitoring until the patient's blood pressure is less than 160/100 mm Hg; however record review shows that medical providers do not follow the EMR template treatment plans. Thus, EMR templates are outdated and/or not followed, and patient health is put at risk.

My review also showed that documents have also been mislabeled, misdated or scanned into the wrong inmate's medical record. Further, hospital and specialty services reports are not timely obtained and scanned into the record if at all. Such inaccurate recordkeeping increases the risk that medical and mental health providers will not have all relevant medical information needed to treat the patient, increasing the risk of harm.

Examples include the following:

- On June 13, 2016, staff scanned a patient's May 13, 2016 initial mental health treatment plan into the EMR under the June 13, 2016 date. The same patient's June 2016 MAR is mislabeled as segregation rounds.[74]

- On January 26, 2016, an incomplete HIV telemedicine note was scanned into a patient's record with another patient's HIV telemedicine note attached to it.[75]

- On July 12, 2015, a NP documented a chronic disease note in the wrong inmates' record, noting diseases he did not have.[76]

- A patient with glaucoma had multiple ophthalmology appointments, but most reports containing clinical findings were not scanned into the EMR.[77]

- A record of a patient with COPD hospitalized on three occasions, from October 31, 2015 to June 16, 2016, did not have complete hospital records for each admission.[78]

Other examples of inaccurate health record keeping is that nurses incorrectly transcribe new medication orders by crossing out the dates of previous medication orders and writing new dates on the medication administration records (MAR). This defaces the MAR and increases the risk of medication transcription errors. Nurses should transcribe each medication order as a new order onto the MAR.

Another example of poor health record management is that the physician and nurse practitioners do not review lab and other diagnostics within 24 hours as required by the MDOC/Centurion Health Services Contract (Article III. 3.1.2.) and do not timely address abnormal test results. This includes a patient with acute renal failure and patients with poorly controlled diabetes and thyroid disease.[79] The failure to timely review lab reports, particularly critical labs, increases the risk that patient's serious medical conditions will not be timely treated.

In summary, poor management of health records results in a lack of timely health information necessary to treat the patient, as well as inaccurate health records. This increases the risk of harm to patients from incomplete and inaccurate records.

Medication Administration Process and Medication Administration Records

[74] Patient #1.
[75] Patient #10.
[76] Patient #4
[77] Patients #12 and #13.
[78] Patient #2.
[79] Patients #7, #12.

Another access to care issue concerns timely, safe, and reliable access by a patient to his correct medication. I evaluated pharmacy and medication services by reviewing applicable policies and medical records, including MARs, and by observing nurses administer medications in general population and segregation housing units. Based on this review, I have determined that the current medication administration process at EMCF is inconsistent from housing unit to housing unit, is dangerous, and does not ensure the "Five Rights of Medication Administration": that the right patient receives the right medication, at the right dose, by the right route, at the right time. In addition, nurses do not consistently document administering medications onto MARs contemporaneously with the medication being given, rendering the MARs unreliable. MARs also show multiple problems with respect to continuity of medications and nursing documentation.

For example, I observed three nurses administering medications to patients, and each had a different process, and none of the nurses conformed to all generally accepted standards of nursing practice for medication administration. One nurse wore gloves throughout the process. She then touched multiple different surfaces (e.g., medication cart, MARs, etc.) without changing her gloves. There was no hand sanitizer or water on the cart to provide to patients to take their medications. The nurse correctly used the MAR to determine what medications the patient was supposed to receive. She retrieved the patient's blister pack and punched mediations from the blister pack into her hand which she then placed in an individual patient cup. Four out of five inmates came to the window without their identification badges and the nurse sent them back to retrieve their identification, and to bring a cup of water before she administered medications to them. Neither a nurse nor an officer consistently performed oral cavity checks to ensure that inmates swallowed their medications, though the nurse documented the distribution onto the MAR at the time of administration.

On another unit, I did not observe whether or not the nurse washed her hands as medication administration was already in progress. But the nurse did not use the patient's MAR to determine what medications the patient was supposed to receive. She simply took the blister pack out of the drawer and punched the medications into a cup. She documented administering medications onto the MAR *before* she administered the medications to the patient, not after the patient swallowed the medication. By not comparing the medication order on the MAR to the medication order on the patient's medication blister pack, the nurse could not know whether the two orders matched. This increases the risk of medication error and is an unsafe practice. The nurse also noted that a few inmates were not in their housing unit, and poured their medications into a coin envelope that was not properly labeled with the same information contained on the pharmacy-labeled blister pack (inmate identification and medication information). She then left to go to the inmate's location to deliver the envelopes to the inmate. A coin envelope is not a proper container for medications as loose pills can fall out of the envelope.

In segregation (Housing Units 5A and 5B), the nurse did not have hand-sanitizer on the medication cart or water to give to patients to take their medications. The nurse did not use the patient's MAR to determine what medications the patient should receive. She prepared

patient medications by placing pills into coin envelopes with only the inmate's last name and no identification number. The nurse went cell to cell and called out to the inmate. In some cells, the nurse could not see the inmate because the window was obscured with a metal grate. She delivered the medication based upon the inmate's cell location and did not positively identify the inmate with an identification badge or verbal name confirmation. In each case, she slid the medication envelope through a crack in the side of the door and did not observe any inmate take their medications. This is dangerous as the nurse had not confirmed the identity of the inmate in the cell and might have given the wrong medication to the wrong patient. In addition, since the nurse did not observe the patient taking the medication, the nurse cannot reliably document that the patient took the medication. The nurse also delivered medications to inmates in recreation cages who did not have any water to take their medications. In addition, when I asked the nurse what would happen when an inmate was not present on the tier when medication rounds were performed, the nurse reported that the patient would miss his medication and have to wait until the next dose. Since inmates have no control over when they are off the tier, staff should have a procedure for ensuring that patient's timely receive their medications either prior to leaving the tier or upon their return. In addition, the nurse did not document administration of medications at the time they were administered. The lack of consistency in nursing medication administration increases the risk of errors as well as inaccurate documentation in the health record.

In addition, I reviewed numerous MARs that showed widespread problems reflecting broken medication processes. These include:

- Delayed administration of newly ordered medications;[80]
- Multiple blank spaces in which nurses have not documented whether medication was administered to the patient;[81]
- Medication nonadherence not timely addressed by nurses or medical providers;[82]
- Medication discontinuity from failure to timely renew chronic disease medications;[83]
- Medication discontinuity from failure to timely refill chronic disease medications;[84]
- Medication discontinuity from provider failure to timely order medications following hospitalization or specialty services;[85]
- Physician failure to timely cosign medication orders;[86]
- Nurses incorrectly transcribing new medication orders onto an existing medication order by defacing the MAR and changing the dates of the previous order;[87]
- Nurses independently withholding insulin and not notifying the physician;[88]

[80] Patients #1, #3, #9, #10, #11,
[81] Patients #3, #13,
[82] Patients #1, #2, #3, #9,#10, #13, #18
[83] Patient #7.
[84] Patients #2, #7, #13, #18
[85] Patients #1, #13.
[86] Patient #2.
[87] Patient #1 #2.

- Nurses administering medications after the medication order has expired;[89]
- Nurses falsifying medication administration for dates that the patient is in the hospital.[90]

Taken together, the medication administration and recordkeeping systems at ECMF do not ensure that patients receive timely administration of ordered medications for their serious medical conditions, medication continuity is not provided for treatment of their serious medical conditions, and the medication records are unreliable. These errors rise to a systemic level and create a risk of serious harm to patients.

Policies and Procedures

Policies and procedures are one component of an adequate health care system. They provide expectations and guidance to staff to meet the requirements of the health care program. Inadequate policies and procedures often result in lack of consistent and timely care, and increase risks of harm to patients.

To assess this area, I reviewed Centurion's current policies and procedures, which are based on National Commission of Correctional Health Care (NCCHC) Standards for Health Services in Prisons and American Correctional Association (ACA) Standards, and which were last revised on November 2, 2015. Based on my review, I have concluded that Centurion's current policies and procedures are inadequate to support health care delivery at EMCF.

Centurion's current policies and procedures are not site specific with respect to EMCF local operating procedures and thus do not provide adequate operational guidance to health care staff. In addition, the policies appeared to be incomplete and were not presented in a manner consistent with staff use. For example, a table of contents was not included in the documents provided for our review. Nor is there a signature page indicating that the policies and procedures had been reviewed and approved by EMCF's Health Services Administrator, Medical Director or Director of Nurses. The policies also lacked operational details as to how certain health care operations were to take place, such as sick call and medication administration.

An unsurprising consequence is that EMCF staff practices do not comply with Centurion policies and procedures, placing inmates at risk of harm. For example, the policy[91] for inmates to access health care states that the system is to be conducted in a manner to protect the confidentiality of the patient request. Typically, this is accomplished by inmates being able to submit their MSRs into a locked box accessed only by health care staff. However, during tours of the housing units, inmates universally reported that in order to access health care, they must give their MSRs to correctional officers who placed the requests in the sick call box, located

[88] Patient #3.
[89] Patient #7.
[90] Patients #2, #5.
[91] Non-Emergency Health Requests and Services. E-07. Revised November 2, 2015.

outside the housing units. Even assuming that this process was followed in all instances, EMCF patient requests are at a minimum not handled confidentially, potentially inhibiting inmates' request for care. The policy should describe how inmates will be able to confidentially submit their medical services request forms, specifically in light of the conditions at EMCF.

The policies also lack adequate guidance in procedures necessary to protect patient health and safety, increasing the risk of harm to patients. For example, the policies do not include a procedure for administering medications in general population and segregation that ensures that patients are properly identified prior to nurses administering medications and that ensures that patients actually ingest their medications. The lack of an adequate procedure was reflected in the observation that nurses inconsistently administered medications in different housing units, and instead engaged in practices that imperiled patient health.

And, in some cases, EMCF is not compliant with its own policies and procedures. An example is that clinic examination rooms (e.g., physician's examination room) are not standardized with medical equipment and supplies required by policy. This shortcoming inhibits the performance of adequate medical evaluations to timely diagnose and treat patient medical conditions, increasing the risk of harm to patients. EMCF leadership should revise the policies and procedures to ensure that they include sufficient operational directives that conform to Centurion policies and procedures and the MDOC/Centurion Health Services Contract.

Continuous Quality Improvement and MDOC Oversight

The purpose of a continuous quality improvement (CQI) program is, among other things, to improve the timeliness and quality of health care. A CQI program identifies health care aspects to be monitored,[92] establishes performance thresholds, implements and monitors corrective actions, and monitors the effectiveness of the corrective action plan. To implement an effective CQI program, health care leadership should establish a quality improvement committee with representatives from major program areas (e.g., medical, nursing, pharmacy, custody, etc.). The committee should meet as frequently as necessary to monitor and correct problems. Monitoring should include review of sentinel events, such as unexpected hospitalizations and mortalities, to determine if the event was preventable. To assess whether EMCF's CQI program met these and other criteria, I reviewed EMCF policies and procedures, Centurion CQI studies from July and August 2015, and related email correspondence regarding CQI findings. My findings showed EMCF's CQI program to be inadequate.

The EMCF CQI Program (A-06) policy is consistent with NCCHC and ACA standards. However, EMCF's implementation of its CQI program is lacking. I was provided CQI studies performed in July and August 2015, which both identified problems that were still systemic at EMCF one year

[92] Health care aspects to be monitored include the timeliness of nurse and provider sick call responses, completion of infirmary rounds, the percentage of diabetic patients in good glycemic (blood sugar) control, the percentage of diabetic patients with annual foot and eye exams, the timeliness of the receipt of medications, etc.

later and contained evaluations inconsistent with my findings, suggesting that EMCF's CQI program is both ineffective and inaccurate.

For example, the July 2015 CQI studies I reviewed identified the following issues that had not been resolved at the time of my site visit one year later:

- Nurse to provider sick call referrals timely took place in only 67% of cases;
- Patients with poorly controlled diabetes were seen monthly for follow-up in only 57% of cases; and
- Patients with diabetes were given annual eye exams in only 48% of cases;

Centurion CQI correspondence also noted that diabetic glycemic control needed improvement, and identified Dr. Abangan as the person responsible to monitor this issue, but there is no documentation that Dr. Abangan monitored or took any action to improve glycemic control.

In addition, findings in the 2015 studies were also inconsistent with the findings of my review. For example, the CQI studies noted that hypertensive patients were found to have good blood pressure control (BP≤140/90 mm Hg) in 96% of cases. But that is not consistent with the number of poorly controlled hypertension cases I found in my review.

Moreover, I found no indication in the documentation I reviewed that a CQI committee consistently met or performed review of sentinel events, or endeavored to identify the root causes of systemic problems and to develop and implement corrective actions. Thus, it is not surprising that I found the same problems in July 2016 that CQI studies noted in July 2015.

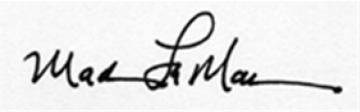
Finally, MDOC's Office of Medical Compliance has a contract monitoring program that involves periodic site visits; however, the program appears to be ineffective. For example, in January 2015, MDOC performed a compliance audit, the results of which noted that medical was not documenting daily rounds in segregation. Six months later, in July 2015, Centurion also noted zero compliance with documentation of medical rounds in segregation. MDOC's audit also noted that conditions were dangerous for nurses during medication administration in one of the housing units, because inmates were out of their cells and walking up behind nurses. But I did not see documentation showing that MDOC or Centurion addressed these problems.[93] More to the point, the mere findings of this review indicate that MDOC lacks a robust contract monitoring oversight program to ensure that its health care vendor provides services to patients that meet minimally acceptable standards.

Thus, based upon the available information, I conclude that the Centurion CQI process is inadequate and does not timely correct either health care processes or the quality of health care. This allows systemic issues with health care delivery and quality to continue and increases

[93] DEF-ESI-0006631.

the risk of harm to patients with serious medical conditions. Moreover, MDOC has failed to effectively remedy the risk to patients that Centurion's management of health care has caused.

Respectfully Submitted,



_____ December 29, 2016

Madeleine LaMarre FNP-BC Date

The opinions in this report, set forth in the Executive Summary and Findings sections of the report, are based on evidence and documentation currently available to me. I reserve the right to modify or expand these opinions if additional information becomes available.

Appendix A – Patient ID Numbers

Patient Number	Name	Inmate ID
Patient #1	[redacted]	[redacted]
Patient #2	[redacted]	[redacted]
Patient #3	[redacted]	[redacted]
Patient #4	[redacted]	[redacted]
Patient #5	[redacted]	[redacted]
Patient #6	[redacted]	[redacted]
Patient #7	[redacted]	[redacted]
Patient #8	[redacted]	[redacted]
Patient #9	[redacted]	[redacted]
Patient #10	[redacted]	[redacted]
Patient #11	[redacted]	[redacted]
Patient #12	[redacted]	[redacted]
Patient #13	[redacted]	[redacted]
Patient #14	[redacted]	[redacted]
Patient #15	[redacted]	[redacted]
Patient #16	[redacted]	[redacted]
Patient #17	[redacted]	[redacted]
Patient #18	[redacted]	[redacted]
Patient #19	[redacted]	[redacted]
Patient #20	[redacted]	[redacted]
Patient #21	[redacted]	[redacted]

EMCF Record Reviews
July 11-15, 2016

Patient #1

This 46-year-old man transferred into EMCF on 5/12/16 at 9:05 pm. He was released from MDOC in September 2015 and readmitted in January 2016. His medical history includes a facial laceration and mandibular fracture with closed reduction (the bone was reset without surgery), schizophrenia and bipolar disorder. His medications are Depakote, Haldol and Benztropine.

On 2/12/16, while the patient was at CMCF (his prior facility), he suffered facial trauma and was sent to the hospital where he had a 5 cm facial laceration and mandibular fracture. His jaw was wired shut to maintain alignment while healing, and he was housed in the CMCF infirmary on clear liquids. During his infirmary stay his wires came out of the brackets and apparently were not replaced.

Intrasystem Transfer

On 5/13/16 at 7:01 pm, an EMCF nurse medically screened the patient. His vital signs were within normal limits (WNL). Weight=194 lbs. The nurse noted that the patient was calm and had dental issues but did not document that the patient was under the care of an oral surgeon.

Initial Mental Health Assessment

On 5/13/16 at 8:59 pm the mental health nurse practitioner saw the patient and ordered Depakote, Haldol and benztropine, as well as labs, and referred the patient to the psychiatrist and to return for follow-up in one month.

Delayed Receipt of Medications

A May 2016 MAR shows the patient received the first dose of Depakote and benztropine on 5/27/16 and first dose of Haldol on 5/31/16.

Oral Surgeon/Specialty Service Lack of Follow-up

On 5/20/16, an ENT[94] specialist saw the patient for follow-up of his jaw fracture. The plan was to see him again in 3 weeks to remove the arch bar from his jaw. A nurse saw the patient upon return from the outside medical appointment. There is no documentation that a medical provider saw the patient after this appointment or requested the ENT follow-up. The ENT specialist did not see him within the requested 3 week time frame.

Medication Nonadherence

On 5/28/16, the patient refused his Haldol injection. On 5/30/16 and 5/31/16, the nurse documented that the patient was a "no show" for morning pill call, and on 5/30/16, the patient

[94] Ear, Nose and Throat Specialist.

was a no show for evening pill call. A nurse referred the patient to a provider for nonadherence.

Mental Health
On 6/1/16, a mental health NP saw the patient for follow-up.

Labs
On 6/3/16, ordered labs were completed. Labs showed that the patient's serum blood level for his mental health medication was therapeutic.

Medical Records Scanning Error
On 6/13/16, staff incorrectly scanned a 5/13/16 initial mental health treatment plan into the EMR under the 6/13/16 date.

Discrepancy with Medication Adherence Assessment
On 6/20/16, a NP saw the patient for follow-up and documented that the patient reported he was adherent with his medications. However his June MAR shows that he had missed almost all of his morning doses. The NP did not appear to be aware of this.

Medical Records Scanning Error/Medication Administration Records/Documentation Error/Medication Nonadherence
The patient's June MAR is mislabeled as segregation rounds. It shows that a nurse crossed out 5/13/16 as the date of the original order and wrote 6/20/16. Thus, the medication received from 6/1/16 to 6/19/16 was from the 5/13/16 order.

The patient was primarily noncompliant with the morning doses of Depakote and Cogentin and compliant with the evening doses.

Sick Call
On 7/5/16, the patient submitted a MSR requesting to change his medical class from E to C/F so he could work in the kitchen. On 7/6/16, a mental health provider documented that she needed to speak with Dr. Nagel.

Assessment: Health care staff did not see this patient for almost 24 hours after his arrival. A NP ordered his psychotropic medications on 5/13/16, but they were not administered to the patient until 5/28/16. The mental health NP referred the patient to Dr. Nagel, but he had not seen the patient as of my visit. The patient saw an ENT specialist and required medical follow-up, but Dr. Abangan did not see the patient, review or address the ENT's recommendation, and the patient did not receive requested follow-up. The NPs documented that the patient was compliant with his medications when MARs show he was not receiving them. And documents are mislabeled in the medical record. Each of these errors represent breakdowns in health care systems that resulted in delayed continuity of care, lack of follow-up and inaccurate medical record keeping, all of which increased risk of harm to the patient.

Patient #2

This 49-year-old man arrived at EMCF in 2009 and transferred to MSP on 6/22/16. His medical history includes asthma, COPD with oxygen dependency, acute respiratory failure, anorexia, weight loss, paranoid schizophrenia and major depressive disorder. His medications are Ipratropium/albuterol nebulized treatments, Alvesco, albuterol inhaler, prednisone, Haldol, sertraline, ensure, naproxen, Benadryl and omeprazole.

Physician Encounter

On 9/1/15, Dr. Abangan saw the patient for difficulty breathing and noted note he was given decadron and taking inhalers for treatment of chronic obstructive pulmonary disease (Alvesco and Xopenex). He noted the patient is newly diagnosed with emphysema and bronchitis. He did not examine the patient but noted his vital signs and oxygen saturation of 87%. He sent the patient by van to the emergency room (ER) for evaluation.

Sick Call

On 10/13/15, the patient submitted a MSR requesting to see the doctor to listen to his lungs. He stated that breathing caused him pain and that he had a hole in his right lung. He wrote, "Please help me." On 10/13/15, a nurse received and triaged the request and saw the patient. The patient weighed 132 lbs. He was afebrile. BP=104/75 mm Hg. The patient was tachycardic (pulse=107/minute) and respirations=26/minute. His oxygen saturation was extremely low (79%, normal=>95%). The nurse noted shortness of breath and rattling in his chest.

Physician Did Not See Patient for Urgent Encounter

The nurse referred the patient to Dr. Abangan *who did not see the patient*. On 10/13/15, he ordered Azithromycin and a Medrol dose-Pak. This medication was not started until the following day. That same day, an LPN ordered a chest x-ray that was cosigned by the physician on 10/14/16.

Physician Did Not See Patient for Urgent Encounter

On 10/14/15 at 9:52 am, the physician ordered IM SoluMedrol. He did not examine the patient.

Radiology

On 10/14/15 at 10:00 am, a chest x-ray showed severe COPD and central cor pulmonale, but no acute pulmonary infiltrates, masses or pleural effusions. The report was completed and faxed to the facility the same day and an LPN reviewed the report at 6:20 pm. On 10/15/15, the physician reviewed this report but despite the severity of the x-ray report, he did not see the patient for five days

Physician Encounter

On 10/19/15, the physician saw the patient for the 10/13/16 MSR, noting that the patient had severe COPD and was given SoluMedrol the prior week and was now on a Medrol dose pack. The physician performed no pulmonary or cardiovascular (CV) review of systems (ROS). He did not review the patient's medications. He noted that the patient's lungs were clear, but not

tight and there were no wheezes. The patient's vital signs were as follows: Oxygen saturation=96%. Weight=135 lbs. BP=112/80 mm Hg, Pulse=102/minute, respirations=22/minute, Temperature=not measured. Dr. Abangan's assessment was the patient's COPD was controlled and he planned to continue the same medication. He did not document a plan for a follow-up appointment. The next day the patient was given an influenza vaccination.

Medication Administration Records
October 2015 MARs showed that the patient was receiving his mental health medications and COPD inhalers were given to the inmate or "keep on person" (KOP).

Urgent Encounter
On 10/31/15 at 2:21 am, the patient presented urgently with severe difficulty breathing, shortness of breath, and audible wheezing. The nurse did not document onset and duration of symptoms. His oxygen saturation was dangerously low (SpO2=80%). The nurse gave him nebulized albuterol and his oxygen saturation increased to 84%, but he was still experiencing difficulty breathing with audible wheezing. Weight=140 lbs., BP=163/96 mm Hg, pulse=83/minute, respirations=27/minute and temp=97.2 F. (Fahrenheit). The nurse re-measured the patient's oxygen saturation which ranged from 79% to 88%. The nurse contacted the on-call provider, and the patient was sent to Anderson Regional Medical Center's emergency department where he was admitted and treated for COPD and acute bronchitis. He improved and his oxygen saturation remained in the 90's% off oxygen. On 11/2/15, he was discharged back to EMCF and was prescribed Symbicort, albuterol inhaler, steroid taper and 5 more days of antibiotics. On 11/3/15, the hospital report was received at EMCF. The physician did not sign it as being reviewed.

Hospital Return/Physician Did Not See the Patient
On 11/2/15, a nurse saw the patient upon his return from the hospital. The nurse documented that the patient said: "I told them I was getting sick. I really did need to go to the hospital. Feeling better now." The nurse noted the medications prescribed at the hospital, except for Symbicort, and that the physician would order the medications. The patient's oxygen saturation was 95%. The nurse documented that Dr. Abangan released the patient to his housing unit. However, Dr. Abangan did not medically evaluate the patient to determine whether he was stable enough to return to his housing unit. He ordered the discharge medications, but not the patient's Symbicort. He ordered no clinical follow-up for the patient. The patient did not receive ordered medications until 11/4/15 at 9:00 pm, more than two full days after his release from the hospital.

Sick Call Request Not Addressed/Medical Record Scanning Error
The EMR contains an incorrectly scanned note dated 12/1/15. However it is an 11/10/15 inmate request form for emergency medication refill, requesting his Symbicort that was ordered by the outside hospital. No staff member signed or dated the form. This suggests that the patient's request was not received by health care staff for 3 weeks after it was submitted.

Chronic Disease Appointment Did Not Take Place
On 11/22/15, the patient was scheduled for chronic disease management, but the appointment header is noted as having been refused. There was no other information in the note or any indication of if or when the visit was rescheduled.

Sick Call Inadequate Nursing Assessment
On 11/23/15, the patient submitted a MSR requesting Symbicort for his lungs. On 11/24/15, the nurse saw the patient. His vital signs and oxygen saturation were normal. The nurse did not auscultate (listen to) the patient's lungs and planned to refer the patient to the physician.

Medication Administration Records/ Medication Nonadherence
November 2016 MARs show that the patient missed approximately 7 doses of his morning psychotropic medications.

Mental Health
On 12/1/15, mental health saw the patient who reported "I'm good here. I just need to see the medical doctor. They not (sic) doing anything here for me. I'm straight with you though." The mental health provider noted that the patient was irritable and agitated, his medications were working and he denied depression and anxiety. The patient stated that he slept without issue, unless he had a "breathing attack." The fact that he was awakened at night with difficulty breathing suggests that his COPD was not well-controlled.

Physician Encounter
On 12/1/16, Dr. Abangan saw the patient for follow-up for his COPD. The physician performed no pulmonary or CV ROS. He did not inquire about frequency of symptoms, exercise tolerance or use of the rescue inhaler. Thus, he was not aware that the patient was periodically awakening at night with shortness of breath, as he had told mental health staff the same day. He did not address the hospital recommendations or the patient's request for Symbicort. Vital signs WNL. The physician documented that the patient's lungs were clear. Dr. Abangan's assessment was COPD but he did not assess disease control. The plan was to continue the same medication. There was no follow-up plan.

Chronic Disease Management
On 12/6/15, the nurse practitioner (NP) saw the patient for chronic disease management. The NP noted the patient's hospitalization in October for hypoxemia (low blood oxygen). The patient presented with shortness of breath with exertion and wheezing. He denied fever, chills or vomiting. The NP took a pulmonary ROS including frequency of symptoms and inhaler use. The NP ordered Rocephin, Zithromax, SoluMedrol, Medrol dose pack and Symbicort. The NP assessed the patient as having severe COPD in poor control and planned to see the patient in 3 months.

On 12/10/15, Dr. Abangan submitted a non-formulary request for Symbicort.

Sick Call
On 12/11/15, the patient submitted a MSR stating that he needed a cold pack. On an undocumented date, a nurse noted that the patient went to Anderson Regional Medical Center's emergency department for this "issue."

Urgent Event
On 12/13/15 at 4:45 am, a RN saw the patient urgently for shortness of breath with rales (abnormal lung sounds) in all 4 quadrants of the patient's abdomen. His oxygen saturation was dangerously low (SpO2=69% and 72%). The RN sent the patient offsite to the hospital by ambulance. Later that day, the patient returned and was seen by the NP.

Pharmacy-Physician Dose Clarification
On 12/14/15, the pharmacist contacted the physician to clarify the Symbicort order. The pharmacist noted that it was usually dosed 2 puffs twice daily but the order was written for 1 puff twice daily. Anderson Regional Medical Center noted that it was dosed as 2 puffs twice daily. Dr. Abangan wrote to give the medication as he had ordered. The patient was given one puff twice a day.

Urgent Event
On 12/20/15, staff saw the patient urgently for incoherence and oxygen saturation of 75%. Staff treated him for ingestion of unknown drug with activated charcoal and did not send him to the emergency department. This was not appropriate as the patient did not receive a medical evaluation and diagnosis for his incoherence, which may have been related to his poorly controlled COPD.

Medication Discontinuity or Nonadherence
December MARs show that the patient's Alvesco was last dispensed on 10/2/15 and Xopenex last ordered on 7/9/15.

Medication Transcription Error
On 1/2/16, a LPN entered an order for Xopenex and Alvesco. The LPN transcribed the order onto a current MAR by crossing out the date of the original order on 7/10/15 and entering 1/2/16 and crossing out the previous order expiration date and putting in a new date of 7/2/16. Although the two orders were the same, this practice increases the risk of transcription and medication errors because sometimes the new order is of a different dosage.

Urgent Event
On 2/2/16 at 12:45 am, a RN saw the patient urgently for extreme difficulty breathing. The patient stated that he, "Can't breathe deep down." The nurse did not perform any assessment including listening to the patient's lungs. BP=118/64 mm Hg, pulse= 98, respirations=30/minute and oxygen saturation=79%. The nurse gave the patient two albuterol treatments and the patient's oxygen saturation increased to 84%. The nurse placed the inmate on oxygen at 4L/minute and the patient's oxygen saturation increased to 94-96%. The nurse called Dr.

Abangan and informed him of the patient's status, treatments rendered, and patient status after treatment.

At 1:26 am, a nurse documented that the patient was going to be transported to Rush Hospital. On 2/2/16 at 3:55 am, the patient returned from Rush Hospital and stated, "they gave me a shot and I feel much better." The patient was given a prescription for Medrol dose pack and prednisone 20 mg two tablets daily.

Urgent Event-Inadequate Nursing Assessment
On 2/2/16 at 10:00 pm, the patient presented to medical with shortness of breath and oxygen saturation of 61%. The nurse performed no other assessment. The nurse did not describe the patient's general condition, appearance, or color, listen to the patient's lungs, or take vital signs. The nurse administered two albuterol treatments and the patient's oxygen saturation increased to 94%. The patient's shortness of breath decreased.

Lack of Physician Follow-up after Hospitalization
The following week neither the physician nor NP saw the patient.

Urgent Event-Inadequate Nursing Assessment
On 2/11/16 at 12:23 am, the patient presented urgently with shortness of breath and being unable to breathe. The nurse did not perform any assessment. The nurse did not take vital signs, oxygen saturation, or listen to his lungs. There is no documentation that the nurse spoke with the physician. The patient was sent out via ambulance. On 2/11/16 at 1:39 am, the patient returned and told the nurse that "my lungs were swole up." The hospital discharge orders included SoluMedrol (steroid medication).

Hospital Return-Lack of Follow-up
On 2/12/16, a medical provider did not see the patient for follow-up.

Urgent Event-Inadequate Nursing Assessment
On 2/14/16 at 5:34 pm, the patient presented urgently to the nurse stating that he could not catch his breath. The nurse did not measure the patient's vital signs or listen to his lungs. Oxygen saturation was 85%. The nurse gave an albuterol treatment and his oxygen saturation increased to 93%. The RN called the NP who ordered SoluMedrol.

Urgent Event-Hospitalization
On 2/17/16, the patient was sent to the emergency department with shortness of breath. Weight=63.5 kg. The patient was admitted and treated for acute COPD exacerbation. Nursing staff notified Dr. Abangan that the patient was sent out by ambulance.

Medication Documentation Error
On 2/18/16, the MAR shows that the nurse gave the patient his evening Haldol, however, the patient was at the hospital.

Infirmary Care
On Friday, 2/19/16 at 2:40 pm, the patient returned and, at 8:28 pm, a RN saw the patient. BP=110/75 mm hg, pulse=110/minute, Resp=22/minute and Temp 98.3%, O2 sat=90%. The nurse did not listen to the patient's lungs. The patient wished to return to his housing unit but was placed in the infirmary in sheltered housing status. The nurse did not document notifying a provider to obtain orders. The nurse gave the patient Symbicort with orders for 2 puffs twice daily.

Delayed Physician Review and Signing of Medication Order
Dr. Abangan signed the nurses' note and medication order on 2/24/16.

Inadequate Nursing Assessment
On 2/20/16 at 4:20 am, a nurse wrote a note stating that the patient reported that "I can't breathe when I pee. When I eat my stomach cramps and I can't breathe." The nurse performed no assessment, documenting only that the patient was calm and pleasant, and that he should continue to be monitored for safety.

On 2/20/16 at 5:33 pm, a nurse documented that the patient stated he was "ok." No vital signs or assessment was performed.

Inadequate Nursing Assessment
On 2/21/16 at 7:14 pm, a RN documented that the patient was awake for morning pill call and continued to ask when he could go back to his unit. The nurse performed no assessment of any kind (vital signs, lungs, oxygen saturation). It was noted that he should continue to be monitored.

Lack of Physician Evaluation Prior to Discharge from the Infirmary
On 2/22/16 at 1:51 pm, the RN documented that the patient was discharged from sheltered housing and sent back to his housing unit per order of the Health Services Administrator. The patient was not seen by a physician or NP prior to discharge.

Physician Encounter
On 2/24/16, the physician saw the patient and documented the following:

> S: Follow-up of COPD.
> O: Lungs clear, no wheezes, O2 Sat 93% on room air, IM on Symbacort (sic). Weight=138 lbs., BP=120/80 mm Hg, pulse=97/minute, respirations=16 and Temp=98.7.
> A: COPD Better.
> P: Continue same Medication.

The physician documented review of the hospital report and discharge orders. He did not document a plan for follow-up.

Sick Call
On 4/27/16, the patient submitted another MSR requesting a steroid shot because his lungs were clogged up. On 4/28/16, a nurse saw the patient, who reported shortness of breath, chest tightness and being out of his inhaler. The nurse noted the patient had diminished breath sounds. BP=117/81 mm Hg, pulse=90/minute, respiration=24/minute. Afebrile. Oxygen saturation=87%. The nurse gave the patient a nebulizer treatment and notified the physician who ordered SoluMedrol. The physician did not see the patient.

Physician Encounter
On 5/2/16 at 1:34 pm, the physician saw the patient for acute COPD exacerbation. Temp=99.6, BP=106/93 mm Hg, pulse=104/minute respirations=22, weight=113 lbs. O2 Sat=83%. The physician did not document a history, pulmonary or CV ROS, an examination of the patient's lungs, or any examination at all. His diagnosis was COPD and he planned to order Medrol Dose pack and Levaquin. He did not order monitoring of any kind.

Nurse Practitioner Encounter
On 5/3/16, a NP saw the patient, who reported having shortness of breath for two weeks. He stated he was in the clinic the day before for the same problem. He stated that he had been throwing up and coughing up yellow-green sputum. The NP noted that the patient appeared anxious, and his respirations was labored and rapid, his skin was W/D (warn and dry), and his color WNL. He also wheezed when he coughed. The NP's assessment was respiratory distress. She ordered chest and abdominal x-rays and an albuterol treatment. The chest x-ray showed right middle lobe opacities consistent with pneumonia. Dr. Abangan wrote a note and sent the patient to the emergency department. The patient was transported by ambulance to the emergency department and admitted in acute respiratory failure. *The physician had missed this diagnosis when he saw the patient the day before, because he performed no medical evaluation of any kind.*

On 5/5/16, MAR shows that the nurses gave the patient his morning and evening Haldol, sertraline, naproxen and guaifenesin but the patient was at the hospital.

On 5/6/16, the patient was discharged back to the facility.

Physician Encounter
On 5/9/16, the physician saw the patient for follow-up. He noted that there was no wheezing; he was breathing well. The physician's assessment was that the COPD acute exacerbation had resolved, and to continue the same medication as prescribed.

Hospitalization
On 6/16/16, the patient was admitted to Rush Hospital with a four-day history of worsening shortness of breath, cough, sputum production and nasal congestion. He was so short of breath he could not walk to medical and his oxygen saturation was in the 60% range. With supplemental oxygen, the patient's oxygen saturation increased to the 80% range. The hospital physician noted that this was the third hospitalization for acute exacerbation of COPD with the

last admission in early May 2016. The patient was evaluated for home oxygen and could not return to EMCF, and the patient was to be transferred to MSP.

On 6/22/16, the patient was discharged and transferred to MSP. His weight was 150 lbs.

Assessment: This patient's care showed multiple failures, including the physician's inadequate medical evaluations; lack of timely physician follow-up after hospital discharge; failure to follow discharge medication recommendations to control the patient's COPD; failure to timely monitor the patient in the infirmary; and failure to see the patient timely in chronic disease clinic in accordance with his disease control. In addition, nursing assessments were also inadequate; on two occasions, nurses documented administration of medications to the patient while he was in the hospital, which was a falsification of the medical record.

Patient #3

This 62-year-old man arrived at EMCF in 2009 and transferred to MSP on 4/28/16. His medical history includes diabetes, hypertension, hypothyroidism, asthma, and schizophrenia. His medications are Lisinopril, synthroid, aspirin and fluphenazine deaconate.

On 5/10/15, his thyroid tests were normal (TSH=0.667).

On 8/12/15, the patient was prescribed Lantus insulin 40 units at bedtime.

Chronic Disease Management

On 10/11/15, a NP saw the patient for chronic disease management. The NP noted that he had a history of hypertension and hyperlipidemia. The NP did not address his diabetes or hypothyroidism. He denied headache, dizziness or slurred speech. The NP did not inquire about CV symptoms such as chest pain, shortness of breath, or palpitations. The NP documented reviewing labs with the patient, but did not document which labs she reviewed. . The patient's blood pressure was high (BP=174/101 mm Hg and pulse=89/minute). The NP's exam was otherwise unremarkable. The NP assessed the patient's hypertension as being in poor control. The electronic medical record (EMR) template instructions for poorly controlled hypertension are to admit the patient to infirmary or to perform daily BP monitoring until his BP was <160/100 mm hg. This did not occur. The NP assessed his hyperlipidemia status as being in fair control (but did not specify a lab value in her note). The NP assessed the patient's Endocrine Disease Control without specifying what disease she was referring to and included no lab information, such as HbA1c (a diabetes lab test) or TSH (testing thyroid hormone levels), but assessed the patient's endocrine disease control as being improved.

The NP ordered labs and medications. Lisinopril-HTCZ 10-12.5 one tablet daily and clonidine 0.1 now, then repeat in 30 minutes. If BP=>150/100 mg may repeat clonidine 0.1 mg by mouth; weekly blood pressure checks and follow-up in 2 weeks.

On 10/14/15, the patient's labs were as follows: LDL=70. HbA1c=6.4%. Glucose=260. Creatinine=0.98 and BUN=13.

Medication Administration Records Show Missed Doses
An October 2015 MAR showed that the patient received his levothyroxine (synthroid) daily with 2-3 blank spaces. He received his Lisinopril-HCTZ and Risperdal.

Medication Administration Records Show the Patient received insulin
A November 2015 MAR showed that the patient received his Lantus and Novolin insulin.

Optometry Examination
On 11/19/15, the patient had an eye examination. The optometrist noted mild exophthalmos (protrusion of the eyeball) and questioned whether the patient needed a thyroid panel. It does not appear that any action was taken as a result of the optometrist's observation and recommendation.

Mental Health Encounter Regarding Medication Nonadherence
On 12/2/15, the mental health NP documented that the patient was referred to her by nursing staff for not coming to medication administration, not eating well per security reports and not coming to get his insulin and to have his blood sugar checked. He also had a history of catatonic episodes. She admitted him to the infirmary.

Physician Encounter Infirmary Care
On 12/7/15, Dr. Abangan documented an infirmary progress note as follows:

> S: No acute distress noted. Offender has diagnosis of IDDM and HTN, hypothyroid and asthma.
> O: Very cooperative with staff. Able to follow simple commanders. Vital signs taken and noted.
> A: None.
> P: Will continue to monitor.

The physician did not reference any labs regarding any of his conditions.

On 12/8/15, the patient's TSH=0.784 and creatinine was 0.92. On 12/9/15, he was discharged from the infirmary following evaluation by a mental health NP.

On 12/17/15 at 4 pm, BS=340. No insulin was documented as being given. At 4:26 pm, the patient was documented as a no show for his insulin. Since the patient had his blood sugar checked at 4 pm, it's unclear how the patient was a "No Show" for his insulin.

Patient Medication Nonadherence-No Action Taken/Urgent Event
On 12/20/15 at 4:00 pm, the patient was documented as a no show for blood sugar check and insulin.

On 12/21/15 at 5:00 am, the patient was documented as a no show for blood sugar check and insulin.

On 12/21/15 at 5:00 pm, the patient was documented as a no show for blood sugar check and insulin.

On 12/22/15 at 5:00 am, the patient was documented as a no show for blood sugar check and insulin.

On 12/22/15 at 5:00 pm, the patient was documented as a no show for blood sugar check and insulin.

On 12/23/15 at 5:00 pm, the patient was documented as a no show for blood sugar check and insulin.

On 12/24/15 at 5:00 am, the patient was documented as a no show for blood sugar check and insulin.

On 12/25/15 at 12:00 am, a RN responded to a code blue at the patient's location. She documented that she found the patient on his bunk awake but unresponsive. She attempted to rouse the inmate verbally and with mild stimuli. His blood sugar was normal (BS=140), suggesting that his unresponsiveness was not due to hypoglycemia (low blood sugar). After the blood sugar check, the nurse rubbed the patient's shoulders and the patient became combative and attempted to strike nurses and officers. It was not documented that any nurses or officers were hurt. No other action regarding care of the patient was documented.

On 12/25/15 at 5:00 am, the patient was documented as a no show for blood sugar check and insulin.

On 12/25/15 at 5:00 pm, the patient was documented as a no show for blood sugar check and insulin.

On 12/26/15 at 4:30 am, the patient was documented as a no show for blood sugar check and insulin.

On 12/26/15 at 5:00 pm, the nurse responded to the patient's cell at the time the patient was to receive a blood sugar check. She wrote, "The patient was nonresponsive to myself and officers. Did not give insulin due to patient not eating or drinking." The LPN noted that the patient's respirations were even and unlabored. The LPN did not take vital signs and wrote that the patient would continue to be monitored. The LPN reported the patient's condition to the charge nurse.

On 12/27/15 at 4:45 am the patient was documented as a no show for blood sugar check and insulin.

On 12/27/15 at 7:00 am, an LPN went to the patient's cell to check his blood sugar=137. The nurse documented that the patient was alert and oriented with a pleasant mood. The nurse did not give insulin. She encouraged the patient to eat his breakfast, and he stated he would. The LPN failed to notify the physician of the patient's condition and to receive an order to withhold the patient's insulin. This exceeds the scope of practice for a nurse.

Lack of Medical Bed Space for a Mental Health Patient

On 12/27/15 at 9:51 pm, a RN wrote an extensive note documenting that the patient was refusing meals and not coming for blood sugar checks and insulin. The DON (Director of Nurses) requested that the nurse call a Lieutenant to ask the Warden if the patient could be placed in intake since an officer was already there with another inmate. The nurse documented that the Warden refused this request. The RN contacted the DON and they discussed that intake did not have adequate lighting and no bed and a decision was made for nurses to observe the patient every 2 hours (presumably in his housing unit) until the following day when the physician and mental health could see the patient. However, a nurse did not monitor the patient.

On 12/28/15 at 4:41 am, the patient was documented as refusing his blood sugar check.

On 12/28/15 at 8:00 pm, a RN documented that Dr. Nagel admitted the patient to the infirmary. The nurse documented that no medical orders were given. The patient was curled up in a fetal position. The patient permitted a nurse to take vital signs but was otherwise uncooperative and combative. A nurse did not notify the physician that this diabetic patient had not been taking his insulin for 10 days.

Medication Delay

On 12/28/15, Dr. Nagel gave orders to add lorazepam to the patient's medication regimen. As of 12/30/15 at 4 pm, the medication had not arrived.

On 12/29/15 at 5 am, the patient's blood sugar was 93.

Physician Encounter Infirmary Care

On 12/29/15 at 6:49 am, the physician documented:

S: No acute distress noted. His medical diagnosis of IDDM, HTN, hypothyroidism.
O: Refused morning medical visit and vital signs. UNABLE TO GET VITAL SIGNS.
A: None.
P: Will continue to monitor

The physician did not perform a clinical evaluation of any kind, despite the patient refusing insulin for approximately 10 days.

Mental Health Encounter

On 12/29/15, the mental health NP documented a note that she and Dr. Nagel attempted to interview the inmate who was catatonic. She noted that he had refused medications and been placed in medical observation several times over the past year and episodes have increased since he was taken off Haldol "due to anemia and unknow (n) origin."

On 12/29/15 at 10:21 pm, the NP documented that the patient was more alert and eating.

Nurse Infirmary Encounter
On 12/30/15 at 6:00 am, the nurse documented that the patient stood up, staggered and fell on the floor. The nurse assisted him back to bed and he answered questions appropriately. His blood pressure was low (BP=100/58 mm Hg), pulse=62/minute, resp=16 and afebrile.

Physician Encounter Infirmary Care
On 12/30/15 at 6:51 am, the physician documented:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, hypothyroidism.
> O: Very cooperative with staff. Morning visit and vitals done. BP=88/56 mm Hg, pulse =76 respirations=16/minute and afebrile.
> P: Will continue to monitor.

The physician did not reference the fact that the patient was catatonic, or that he had been refusing meals and medications. He did not perform any clinical examination of the patient, including noting that the patient was hypotensive (low blood pressure).

Delayed Review and Action by Physician to Labs Showing Patient Was in Acute Renal Failure
On 12/30/15 at 11:50 am, the patient's glucose was 448, creatinine 3.79 and eGFR=16, normal=>60. This report was signed by Dr. Abangan on 1/4/16.

Delayed Medication Administration for an Acutely Psychotic Patient
On 12/30/15 at 3:55 pm, the mental health NP documented that Ativan and Risperdal ordered on 12/28/15 had not arrived yet from the pharmacy.

Nursing Infirmary Encounter
On 12/30/15 at 6:00 pm, the patient's blood sugar was high (BS=542, random normal≤150). The nurse did not perform an assessment for diabetic ketoacidosis (DKA) or take vital signs. The nurse gave the patient 40 units of Lantus and 14 units per sliding scale. At 9:10 pm, the patient's blood sugar was still high (BS=492). The nurse did not perform an assessment but notified the physician who ordered the patient sent to the emergency department per van instead of ambulance.

Urgent Care Transport Issue
On 12/31/15 at 12:26 am, the patient returned from the hospital after refusing to get out of the van.

A nurse documented the following note:

> Returned to sheltered housing unit after refusing to get out of the van at Anderson Regional Medical Center's emergency department. Refused treatment. Accompanied per 2 guards. Alert and makes brief eye contact. Flat affect and answers questions with 1-2 word answers. Generalized weakness, requires moderate assist with standing and transfers. Unable to sit up on his mattress without leaning backwards into the wall. BP=118/60 mm Hg, pulse=68/minute, respirations=16 and temp=98.6, oxygen sat=97%. Respirations even/unlabored, skin s/d color WNL. Accucheck=417. Will notify Dr. Abangan of patient's refusal and return to sheltered housing.

The nurse did not document notifying Dr. Abangan or any treatment provided for the patient's hyperglycemia.

On 12/31/15 at 5:31 am, the patient's glucose was 215 and the patient was given 4 units of Novolin per sliding scale.

No Action by Physician to Labs Showing Patient Was in Acute Renal Failure

On 12/31/15 at 5:33 pm, the nurse documented that Dr. Abangan was notified of the 12/30/15 lab results, referenced above, showing that the patient was in acute renal failure. The nurse did not document what the lab values were (glucose= 448, creatinine was 3.79 and eGFR=16), normal=>60) or that the physician gave new orders, including to repeat the labs. This report was signed by Dr. Abangan on 1/4/16. He documented: "IM BUN and Creatinine was up. He was sent to the hospital and refused treatment." The physician did not document a plan for patient follow-up.

Nursing Infirmary Encounter

On 1/1/16 at 12:27 am, the nurse documented that the patient was feeling better but still weak. The nurse performed no other assessment. At 4:00 pm, a nurse documented that the patient's BS=202 but was not given insulin because the patient was not eating. The nurse did not notify a physician to receive an order to withhold insulin.

On 1/2/16, a nurse documented that the inmate did not take his medication because she scared him when she waked him. She documented that he was deteriorating mentally, and that he was not stable and would continue to be monitored. There is no documentation the nurse notified the physician or mental health staff.

On 1/4/16, a nurse documented that the patient was not as confused as previously. The same day, a Licensed Social Worker saw the patient and noted he was improved.

Physician Infirmary Encounter

On 1/5/16 at 7:53 am, the physician documented:

> S: No acute distress noted. Has medical diagnosis of IDDM, HTN and hypothyroidism.

O: Very cooperative with staff. Vital signs taken. BP=131/76 mm Hg, pulse=119 respirations=18/minute and 97.7.
A: Encourage patient to push fluids.
P: Will continue to monitor.

The physician did not assess the patient's mental status or address the patient's recent abnormal creatinine and BUN, reflecting the patient was in acute renal failure.

Physician Infirmary Encounter
On 1/6/16 at 7:28 am, the physician saw the patient and documented the following note:

S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism.
O: Very cooperative with staff. Morning vital signs taken and medical visit done.
BP=138/73 mm Hg, pulse =97 respirations=16/minute and 98.7.
P: Will continue to monitor.

The physician did not assess the patient's mental status or address the patient's recent abnormal creatinine and BUN, reflecting the patient was in acute renal failure.

Mental Health Encounter
On 1/6/16, the mental health NP documented that she saw the patient with Dr. Nagel and that they agreed his catatonic symptoms had resolved. Dr. Nagel did not document a note. The NP and Dr. Nagel decided to discharge him for psychiatric purposes and turn his case over to medical for evaluation for discharge.

Physician Infirmary Encounter
On 1/7/16 at 7:57 am, Dr. Abangan saw the patient and documented the following note:

S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism.
O: Very cooperative with staff. Morning visit and vital signs done.
BP=144/77 mm Hg, pulse =101 respirations=18/minute and 97.8.
P: Will continue to monitor.

The physician did not reference the patient's abnormal creatinine and BUN but ordered a repeat chemistry panel.

On 1/7/16, the patient's serum chemistry was rechecked and was normal. On 1/11/16, the physician reviewed this report.

Sick Call
On 1/14/16, the patient submitted a MSR stating that he needed something for his stomach. On 1/14/16, a RN saw the patient who complained of being constipated, noting that his bowel

sounded sound sluggish and his was abdomen soft to the touch. The nurse did not inquire about the duration of his symptoms or ask about the quality of his stools and whether they had blood in them. BP=176/81 mm Hg. The nurse gave the patient milk of magnesia and Colace but did not address the patient's severely elevated blood pressure.

Chronic Disease Management
On 1/14/16, a NP saw the patient for chronic disease follow-up. The NP noted the patient's diabetes, hypertension and asthma, but not his hypothyroidism. BP=144/76 mm Hg, pulse=115/minute. The NP documented that the patient denied any ER visits since his last clinic visit. He denied CV symptoms but the NP did not ask about diabetes or thyroid symptoms. He stated that he took all of his medications and was having no side effects. She documented "I have reviewed appropriate labs with the patient" but did not include them in her note. Under asthma, she documented "I have reviewed appropriate labs with the patient." The NP did not include HbA1c nor TSH values in her note. She did not include peak expiratory flow meter values in her note. She assessed the patient's hypertension as being in fair control and worsening; diabetes control as being fair and worsening; and asthma control as improved but there was no basis for these assessments, except for the hypertension. She planned to order blood pressure monitoring every Monday, Wednesday, - and Friday for 2 weeks, labs and to continue the plan of care and see the patient in 3 months.

From 1/20/16 to 1/26/16, the patient refused accuchecks and/or insulin.

Infirmary Admission
On 1/27/16, the patient was admitted for psychiatric observation because security reported he was not eating. The mental health NP planned to continue Risperdal and Cogentin.

Urgent Event
On 1/28/16 at 4:28 am, a nurse documented notifying Dr. Abangan that the patient was unresponsive with an oxygen saturation of 86% and BP=189/99 mm Hg. The patient reported not eating. The nurse gave the patient oxygen at 4L/minute increasing his oxygen saturation to 99%, but when oxygen was removed, his oxygen saturation declined to 86%. BS=111. The patient was sent out to the emergency department via ambulance. On 1/28/16 at 4:28, the nurse also documented that the patient returned from offsite and was feeling better. There was no hospital report, but there were discharge instructions related to schizophrenia and prescriptions for Ativan and Benadryl.

Physician Encounter Infirmary Care
On 1/28/16 at 7:51 am, Dr. Abangan saw the patient and documented the following note:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism.
> O: Refused morning vital signs and visit. UNABLE TO GET VITAL SIGNS.
> A: Remain on Psych observation.
> P: Will continue to monitor.

The MD nor NP addressed the prescription for Ativan and Benadryl.

Sick Call
On 2/15/16, the patient submitted a MSR stating that he needed a cold pack. On 2/16/16, a RN saw the patient. BP=180/81 mm Hg and pulse=114/minute, respirations=18, Temp=98.9 and oxygen saturation=96%. The nurse did not take a history of his onset of symptoms or perform a respiratory ROS. The nurse noted that the patient's chest sounds were clear and the patient was in no distress. The plan was to treat the patient with an antihistamine (Loratadine). *The nurse did not address the patient's poorly controlled hypertension or tachycardia.*

On 3/7/16, the patient' blood pressure was 168/94 mm Hg.

On 3/9/16, his labs were as follows: LDL=81 and HbA1c=7.2%. Other labs to check the patient's blood chemistry, liver function and blood counts were within normal limits.

Urgent Event Regarding Abnormal Vital Signs
On 3/17/16 at 7:00 pm, the patient was admitted to the infirmary for being unresponsive and not taking his medication, food or insulin. Blood pressure=209/119 mm Hg, pulse=119/minute, resp=18 and afebrile. At 10:30 pm, repeat BP=180/105 mm Hg. *No action was documented as being taken, including notifying the physician.*

Mental Health
On 3/18/16, the mental health NP saw the patient and noted that he was catatonic and not eating or coming to medical for accuchecks and insulin. The NP ordered Ativan 1 mg IM daily for 14 days. She completed a nonformulary request. The medication was given and the patient started talking and eating after being given Ativan.

Physician Infirmary Encounter
On 3/21/16 at 8:37 am, Dr. Abangan saw the patient and documented the following note:

> S: No acute distress noted. His medical diagnosis of IDDM, HTN, asthma, hypothyroidism, severely catatonic, been readmitted several times for catatonia.
> O: Patient refused morning vital signs and MD visit. UNABLE TO GET VITAL SIGNS.
> A: Patient remains of Psych/med obs (observation).
> P: Will continue to monitor.

The physician did not address the patients' poorly controlled hypertension noted 4 days prior or conduct any physical examination of any kind.

Chronic Disease Management
On 4/10/16, another NP saw the patient for chronic disease management. BP=160/90 mm Hg, pulse=89/minute. The NP took an asthma ROS but not one for CV, diabetes or thyroid disease. Under endocrine and pulmonary, the NP documented "I have reviewed appropriate labs with

the patient," but did not reference any labs (HbA1c=7.2%) or peak flow meter results (not done). The NP referred to a 3/17/16 infirmary admission, but did not state the reason for the admission. The NP documented that the patient's blood pressure was in fair control and clinical status was stable, but the patient's blood pressure control was significantly worse. The NP documented the patient's hyperlipidemia as in fair control (LDL=130-159), but this assessment was incorrect as the month prior labs reflected that the patient's lipids were at goal (LDL=81, goal≤100). The NP did not assess the patient's hypothyroidism control in the note, but addressed disease control for each disease in the assessment/plan. She planned to increase the patient's Lantus insulin from 40 to 42 units. She did not change the patient's blood pressure medication because he had not taken his morning medication. She assessed his hypothyroidism as being controlled based upon no documentation. She planned to see the patient again in 3 months.

On 4/28/16, the patient transferred to MSP due to his catatonic schizophrenia.

Assessment: This patient did not receive timely and appropriate care for his serious medical conditions, including medical evaluation and monitoring of his acute renal failure while he was catatonic and not taking fluids or meals. The patient was not initially admitted to an infirmary bed, as none was available and the Warden refused the patient to be placed in the Intake Unit. The physician did not review his labs timely or perform adequate medical evaluations while the patient was in the infirmary. Nurses did not notify the physician when the patient's vital signs were abnormal. NPs did not address all of his chronic diseases at each visit and did not adequately evaluate the patient's chronic diseases by obtaining a pertinent review of systems and noting labs. The patient was not monitored in accordance with his poor hypertension control.

Patient #4

This 66-year-old arrived at EMCF in 2011. His medical history includes diabetes, hyperlipidemia, latent tuberculosis infection and schizophrenia. His medication was metformin, Humulin 70/30 and regular insulin, Zocor, Haldol Decanoate, amantadine and diphenhydramine. I reviewed this patient's record in 2014, as well. His care, poor then, has not improved since my last report.

Chronic Disease Management

On 5/17/15, a NP saw the patient for chronic disease management, addressing his diabetes and hyperlipidemia. The NP also noted the patient had hypertension, but at this time, the patient was not being treated for hypertension. The NP documented that the patient denied headache, dizziness, slurred speech or blurred vision at this time. The NP performed no CV ROS to include chest pain, shortness of breath, or palpitations. The nurse documented that she reviewed appropriate labs with the patient, but did not identify which labs. Weight=150 lbs. BP=120/60 mm Hg. The NP performed an examination and assessed the patient's hypertension as being in good control and improved, however at this time the patient was not diagnosed and treated for hypertension; his hyperlipidemia was assessed as being in fair control and improved (the NP assessed hyperlipidemia control in two separate sections of the note); and diabetes control was not clearly documented. The NP planned to continue the plan of care.

On 6/10/15, the patient's blood pressure was elevated BP=162/76 mm Hg.

Chronic Disease Management Note Documented in the Wrong Patient Record
On 7/12/15, a NP saw the patient for follow-up. The NP documented that the patient had a past medical history of asthma, hepatitis C virus infection (HCV) and seizure disorder. However, the patient did not have any of these medical conditions and it appears that the nurse practitioner documented a note in the wrong record. The NP planned to order labs and see the patient in 3 months. This appointment did not occur for 5.5 months.

Physician Encounter Sick Call
On 12/12/15, the patient submitted a MSR complaining of a corn on the bottom of his foot. On 12/14/15, the physician saw the patient and treated the callous with TCA (trichloroacetic acid) until it was gone. BP=134/93 mm hg. The physician did not address the patient's elevated diastolic pressure.

Chronic Disease Management
On 12/28/15, a different NP saw the patient for follow-up of diabetes and hypertension. The NP documented that the patient denied CP, shortness of breath, palpitations, blurred vision or any CV symptoms. He denied ER visits since his last chronic disease visit. He stated that he took all of his medications as ordered. He stated that he does not exercise and does not smoke. He stated he eats what the facility serves him. She documented that he had type 1 diabetes. The patient had a grayish looking right pupil and a large callous on his right lateral foot. She documented that she reviewed appropriate labs with the patient. She documented that his hyperlipidemia status was improved but did not reference labs. She planned to order labs and see the patient in 3 months. She did not note the NP's previous diagnoses of seizure disorder and hepatitis.

On 3/15/16, labs showed the patient's diabetes was well controlled (HbA1c=6.9%).

Sick Call
On 3/11/16, the patient submitted a MSR complaining of his feet hurting, stating that he was diabetic. On 3/12/16, a RN saw the patient. The nurse did not perform an examination of the patient's feet but documented "ongoing treatment of callous area. No S/S of infection." The nurse assessed the patient as having a right outer foot callous and ordered that he continue the same treatment, through 6/14/16. She did not document what the treatment was.

Chronic Disease Management
On 3/23/16, the NP saw the patient for follow-up. He denied CV symptoms, but the NP conducted no endocrine ROS, including for blurred vision. She did not address any labs. BP=119/79 mm Hg. She assessed his diabetes and hyperlipidemia as being improved but did not note the basis for the improved control. She planned to see the patient in six months.

No Eye Examination Since 2013

The patient had not had an eye exam since 3/7/2013. At that time, the optician documented that the patient had a corneal scar and keratoconus and referred the patient to the ophthalmologist. This has not taken place.

Assessment: This patient has not had adequate evaluation of his chronic diseases with pertinent cardiovascular and diabetes review of systems. For most visits, the NPs do not document the basis for the patient's chronic disease control by referencing pertinent labs. The patient has not had an eye exam or ophthalmology follow-up since 2013, reflecting discontinuity of care.

Patient #5

This 40-year-old man arrived at EMCF in 2011. His medical history includes schizophrenia. His medications are buspirone, Zyprexa, diphenhydramine and ibuprofen.

Sick Call

On 11/17/15, the patient submitted a MSR complaining of falling out of bed and hitting his knee on the floor. His knee was swollen and painful. On 11/19/16, the nurse documented that the patient refused treatment. There is a signed refusal.

Sick Call

On 11/30/15, he patient submitted a MSR requesting to be seen as soon as possible to check his blood pressure. He complained of chest pain and stomach cramps. On 12/1/15, a RN documented that the patient refused to come to medical. The patient signed a refusal form.

Sick Call

On 1/18/16, the patient submitted a MSR complaining of having a bad cold and a sore throat. On 1/19/16, a RN saw the patient. The patient had a runny nose, sore throat, head congestion and was coughing up phlegm. The nurse did not take a history of onset or duration of the patient's symptoms. The nurse did not ask about the quality and quantity of his sputum. The nurse did not assess the patient's eyes, ears, nose or throat, or assesse his neck for swollen lymph nodes. The nurse documented only that the patient's chest sounded clear. Weight=145 lbs. BP=148/95 mm Hg, pulse=59 and respirations=18, temp=97.5. The nurse gave the patient loratadine, guaifenesin, and Tylenol. The nurse did not refer the patient to a provider.

Sick Call

On 1/24/16, the patient submitted a MSR complaining of his mouth and face being swollen after he put soap on it. On 1/25/16, a RN saw the patient and noted that the patient complained that the left side of his mouth and face was swollen, and that it had started out as a small bump the previous Friday. The nurse noted that the patient's left top lip was very swollen from above the nose to his lower jaw. The patient complained of 10 out of 10 pain severity. He was afebrile and his vital signs were otherwise within normal limits. The nurse gave the patient ibuprofen 200 mg 2 tabs twice daily for 5 days and referred the patient to a provider, but did not specify urgency of the referral.

Urgent Event
On 1/26/16 at 12:53 am, an LPN documented that at 7:00 pm, she saw the patient with a swollen upper lip. The patient squeezed it and it "blew up." There was a boil on his left upper lip that was red, swollen and hot to touch. The patient reported that he could not eat or sleep due to the pain. The LPN took no vital signs. Per protocol, Bactrim was started. The patient was returned to the housing unit. The LPN ordered Bactrim that was not signed by the doctor. A medical provider did not see the patient on 1/26/16.

Urgent Event
On 1/27/16 at 5:00 am, the RN saw the patient for persistent complaints of severe pain and being unable to eat due to his swollen lip. The nurse noted two areas of purulent appearing pockets. The nurse did not examine the patient's throat or neck for swollen lymph nodes. The nurse did not measure vital signs but documented "no fever noted." The nurse gave the patient two Ensure (supplemental meal replacement) cans and Ibuprofen 800 mg for pain. The Ibuprofen was a prescription dose.

Urgent Event
On 1/27/16 at 6:09 am the RN documented that she saw the patient for "swolled top lip with pain and swelling in face. No fever." Temp=99.6, BP=128/92 mm Hg, pulse=105, resp=22. The nurse did not document a plan. On 1/27/16, the physician signed the nurse's note.

Physician Encounter
On 1/27/16 at 6:00 am, Dr. Abangan saw the patient due to the nurse referral. He noted that the patient was seen 2 days prior with cold symptoms and his upper lip was now swollen with a small crater like lesion on the left upper lip, and that the lip was grossly swollen and tender. He wrote "The IM (inmate) said he is not able to chew his food so he requested something liquid." He diagnosed the patient with herpes simplex and ordered acyclovir and Boost. He made no plans for follow-up. The physician made no reference to the nurse's notes an hour earlier that the patient had two pockets that were purulent.

Emergency Department Visit
On 1/28/16, the patient was sent to Anderson Regional Medical Center with a two day history of a very large abscess on his left upper lip extending into the labial fold of his nose, cheek and forehead. The hospital physician noted facial swelling starting from the lip, which was about 4 times larger than normal size. The diagnosis was left upper lip cellulitis and abscess. The patient was admitted and underwent surgical incision and drainage of his lip and facial area. He was given IV antibiotics and then started on oral medications, Bactrim and Acyclovir. He was to have follow-up in two weeks with the ENT specialist, Dr. Cody Aull. On 1/31/16, the patient was discharged back to the facility with orders for Bactrim twice daily for 14 days and topical mupirocin to apply three times daily.

Medication Administration Records Documentation Error-Falsification of Records
The patient's January 2016 MAR shows that on 1/30/16, a nurse documented giving the patient a 1:00 pm dose of Boost and acyclovir, but the patient was at the hospital.

Medical Records
On 1/29/16 at 5:48 am, a LPN documented that the patient presented with a grossly swollen lip with drainage and swelling to the entire left side of face. The patient had a fever of 100.1 Fahrenheit. He reported weakness and severe pain. The patient was sent out to the hospital by facility van. The security report notes that the patient was sent out on 1/29/16 at 10:45 am. This information is discrepant with the hospital report that the patient was admitted on 1/28/16 and discharged on 1/31/16.

Infirmary Admission Following Hospital Return
On 1/31/16 at 4:44 pm, a RN documented that the patient returned from the hospital and had a wound to his upper lip that was closed with sutures. He had a fever of 101.1 Fahrenheit, BP=143/96 mm Hg, pulse=96, resp=16. The nurse noted the referral to Dr. Cody Aull, ENT in two weeks. He was admitted to the infirmary to be seen by the physician. The nurse gave him ibuprofen for his fever.

Lack of Physician Follow-up.
The physician did not order mupirocin or Bactrim as recommended by the ENT specialist.

On 2/1/16 and 2/2/16, a nurse documented that the patient wanted to return to his unit.

Physician Hospital Follow-Up
On 2/3/16, the physician saw the patient and discharged him from the infirmary. The physician did not review the patient's hospital course. The patient was afebrile and his lip swelling had decreased.

Sick Call
On 2/14/16, the patient submitted a MSR complaining that he had gone to the hospital, where they put a needle in his arm, and that the needle had been in his arm for 4 days. He stated that his veins were painful. The request was date stamped as received on 2/15/16. On 2/15/16, a nurse documented being unable to see the patient due to no movement of prisoners being allowed. On 2/18/16, the nurse saw the patient. The nurse noted that the patient's vein in his right arm was swollen and tender. She gave him Ibuprofen. His vital signs were normal. The patient was not taking Bactrim.

Specialty Service Lack of Timely Physician Follow-up
On 2/16/16, the ENT saw the patient, removed his sutures and ordered mupirocin. An LPN entered this medication into the MAR on 2/16/16, but it was not signed by the doctor until 2/24/16. On 2/25/16, the physician changed the order for mupirocin to bacitracin. The February 2016 MAR shows that the patient was issued mupirocin on 2/26/16 and Bacitracin on 2/28/16.

Physician Encounter
On 3/2/16, the provider saw the patient for follow-up of his lip abscess.

Sick Call
On 3/16/16, the patient submitted a MSR complaining of a cold and sore throat so severe he was unable to swallow his food. He wrote, "Please help me." It was received on 3/17/16, and a RN saw the patient the same day. He was afebrile. The nurse documented that the patient's throat was red and sore. She did not describe any pus in his throat or palpate the neck for swollen lymph nodes. She gave him Guaifenesin, Tylenol and Claritin, but made no referral.

Assessment: The patient did not receive timely evaluation and follow-up for his abscessed lip. LPNs ordered and administered prescription medications without receiving an order from a physician. The patient did not timely receive prescribed medications. Nurses falsified MARs by documenting administration of medications while the patient was at the hospital. There are also discrepancies in the medical record with respect to when the patient was sent to the local emergency room department.

Patient #6
This 32-year-old man transferred to EMCF on 5/9/16. His medical history includes hypertension, chest pain, hepatitis C infection and bipolar disorder. His medications are propranolol, Haldol decanoate and loratadine.

At the prior facility, on 5/31/13, labs show that the patient had a positive HCV antibody test and elevated liver enzymes which suggests that the patient has chronic hepatitis C infection. Labs showed he did not have hepatitis B infection.

On 3/24/16, at his prior facility, the patient was seen for chronic disease management and was due for follow-up in 3 months. His BP=144/79 mm Hg. Weight=193 lbs. The quality of the visit had little substance with no assessment of the patient's hepatitis B and C infection, including whether the patient is chronically infected. No CV or GI ROS. The NP assessed the patient's hypertension to be in good control. The patient was prescribed propranolol.

Intrasystem Transfer
On 5/9/16, the patient transferred to EMCF at 8:05 am. He was transferred because of his psychosis, poor hygiene and refusal to take medications. On 5/9/16 at 7:00 am, the patient was admitted directly to the infirmary.

At 5:26 pm, a RN performed intake screening, noting that the patient complained of dental issues, but was confused with rambling speech and poor hygiene. His vital signs were stable. The nurse did not document a plan. On 5/9/16, the mental health NP ordered propranolol, Zyprexa and benztropine. The psychiatrist saw the patient the same day and reduced his Zyprexa, discontinued his Cogentin and propranolol, and started lithium 600 mg at bedtime.

Physician Encounter Infirmary Care
On 5/16/16, Dr. Abangan wrote an infirmary progress note as follows:

S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
O: Cooperative with staff, morning assessment and vital signs taken.
Temp=98, pulse=77, Resp=16, BP=128/88 mm Hg.
A: Remain on medical in psych observation.
P: Will continue to monitor.

Although the patient had a history of hypertension, the physician did not note that the patient was not currently prescribed medication for hypertension or order labs.

Physician Encounter Infirmary Care
On 5/17/16, Dr. Abangan wrote an infirmary progress note as follows:

S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
O: Unable to obtain vitals. Refused morning assessment. UNABLE TO GET VITAL SIGNS.
A: Remain on medical in psych observation.
P: Will continue to monitor.

The same day, Dr. Nagel added propranolol to the patient's medication regimen.

Physician Encounter Infirmary Care
On 5/23/16, Dr. Abangan wrote an infirmary progress note as follows:

S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
O: Unable to obtain vitals. Refused morning assessment. UNABLE TO GET VITAL SIGNS.
A: Remain on medical in psych observation.
P: Will continue to monitor.

Physician Encounter Infirmary Care
On 5/24/16, Dr. Abangan wrote an infirmary progress note as follows:

S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
O: Unable to obtain vitals. Refused morning assessment. UNABLE TO GET VITAL SIGNS.
A: Remain on medical in psych observation.
P: Will continue to monitor.

Physician Encounter Infirmary Care
On 5/25/16, Dr. Abangan wrote an infirmary progress note as follows:

S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
O: Unable to obtain vitals. Refused morning assessment. UNABLE TO GET VITAL SIGNS.
A: Remain on medical in psych observation.
P: Will continue to monitor.

Physician Encounter Infirmary Care

On 5/26/16, Dr. Abangan wrote an infirmary progress note as follows:

> S: No distress noted. Medical diagnosis of Hepatitis B and C, and hypertension.
> O: Unable to obtain vitals. Refused morning assessment. UNABLE TO GET VITAL SIGNS.
> A: Remain on medical in psych observation.
> P: Will continue to monitor.

Mental Health
On 5/30/16, the mental health NP wrote a note that the patient was refusing medications but did not present a danger to self or others. She noted that he was not a candidate for involuntary medication.

Chronic Disease Management
On 6/24/16, a NP saw the patient for the chronic care clinic. The patient's BP=98/60 mm Hg. Weight=165 lbs. Vitals signs otherwise WNL. The NP documented that the patient had a history of hypertension and denied CV symptoms. He denied any ER visits. She wrote, "I have reviewed appropriate labs with the patient." Under hepatitis, the NP documented only that, "I have reviewed appropriate labs with the patient." There was no assessment of the patient's hypertension or hepatitis B and C disease control, or clinical data. The NP planned to order labs and see the patient in 3 months.

Labs
On 6/24/16, labs show the patient's LDL=59, Complete blood count (CBC) and serum chemistry normal except his liver function tests were increased warranting further clinical evaluation, particularly in light of his positive hepatitis C antibody test.

Medication Administration Records (MARs)
The patient's May and June 2016 MARs show that the patient received his medications in May, but refused all of his medications in June.

Assessment: The physician did not perform meaningful infirmary rounds for this patient for 5 days, including documenting any subjective or objective information, except vital signs on one day. In fact, since nurses take vital signs, there is no documentation to show that the physician even saw the patient. The NP did not perform an adequate assessment of the patient's chronic diseases.

Patient #7
This 53-year-old man arrived at EMCF in December 2014. His medical history includes hyperthyroidism, hypertension, major depressive disorder and hyperlipidemia. His medications are levothyroxine, amlodipine, hydrochlorothiazide, simvastatin, Latanoprost and Zoloft.

Incomplete Problem List
The patient has glaucoma but this was not noted on his Problem List.

On 8/25/14, at his prior facility, labs showed his hyperlipidemia was not well controlled (LDL=146, goal=<100) and his hypothyroidism was well controlled (TSH=2.060).

On 9/3/14, at his prior facility, the patient had a chronic disease visit. As of my visit in July 2016, he had not been seen for chronic diseases since that time.

Optometry Follow-up
On 10/15/14, at his prior facility, the patient had an optometry examination for follow-up of glaucoma. The patient was taking Latanoprost at that time. The optometrist recommended a 4 month follow-up, but this did not take place.

Abnormal Labs
On 5/13/15, his lipids were within normal limits (LDL=94) but his thyroid tests showed that his hypothyroidism was not well controlled (TSH=7.620, normal=.5 to 4.5). No action was taken for this abnormal lab.

Medication Renewal
On 8/15/15, the provider renewed the patient's Latanoprost.

Sick Call
On 8/19/15, the patient submitted a MSR complaining of a painful rash on both hands that was peeling and bleeding. The patient requested to see the doctor as soon as possible. On 8/19/15, a nurse saw the patient. The nurse described the rash and treated the patient with Tolnaftate.

Physician Encounter
On 10/16/15, the physician saw the patient for back pain. He noted that the patients' chronic diseases include scoliosis and thyroid problems. However, the physician failed to note that the patient was also being treated for hypertension and hyperlipidemia.

Urgent Event
On 10/27/15 at 7:23 pm, a Code Blue was called and a nurse responded to the patient's location on his housing unit. The patient reported having chest pain. BP=140/82 mm Hg and pulse=68/minute, O2 sat=96%. The patient was escorted to medical. An EKG showed a slow heart rate (sinus bradycardia) but was otherwise normal. The nurse documented that the patient was monitored for 45 minutes and escorted back to his unit, per the correction officer. The nurse advised the patient to alert staff if he felt bad again. The nurse did not obtain a history of the patient's chest pain, including noting the onset location, quality, severity or radiation, and did not notify the physician. The RN gave Dr. Abangan's nurse a report for the patient to be seen the following day.

Physician Encounter
On 10/28/15, the physician saw the patient for follow-up. His vital signs were normal. The physician did not note that the patient had a history of hypertension and hyperlipidemia. He documented:

S: When patient laughs or coughs it hurts. IM said he has chest pain. No diaphoresis no radiation of the patient, nothing triggers the pain, describes it as stabbing.
O: O2 sat=98% Heart NSR (normal sinus rhythm) lungs clear no pedal edema. Did not review EKG. Vital signs normal.
A: Doubt pain is cardiac origin.
P: CXR (chest x-ray) and Tums.

On 10/30/15 one of the providers ordered annual labs.

Physician Review of Labs
On 11/12/15, labs showed that the patient's hyperlipidemia was controlled (LDL=89); his hypothyroidism was not controlled (TSH=8.2, goal=<4.5); and his diabetes was controlled (HbA1c=5.8%). This report was signed by the physician but no action was taken regarding the patient's hypothyroidism.

Dental
On 11/12/15, dental saw the patient for trauma to the patient earlier that day. The patient had three loose teeth. The dentist indicated that if the three anterior teeth along the mandible were still loose that they would need to be extracted. Dental x-rays did not show a fracture. The dentist ordered antibiotics and ibuprofen and planned to see the patient in one week. The patient received the medication. *The dental follow-up did not take place. Dental did not see the patient again until 1/8/16.*

Sick Call
On 11/23/15, the patient submitted a MSR stating that his Latanoprost eye drop was stolen from under his mattress. He stated that his eyes were hurting and he needed it refilled. The nurse did not see the patient. On 11/30/15, the psychiatrist reordered his eye drops and levothyroxine (thyroid medication). On 12/3/15, the patient was given eye drops.

Medication Error
On 12/10/15, the patient's amlodipine and hydrochlorothiazide orders expired. However, nurses kept giving him the medication until 12/18/15, and it was reordered on 12/22/15.

On 3/22/16, the physician renewed the patient's simvastatin.

Sick Call
On 6/1/16, the patient submitted a MSR stating that his leg was hurting him very badly and it worsened when he walked on it. The request was received the following day. On 6/2/16, the nurse saw the patient. His vital signs were normal. Oxygen Saturation=95%. The patient complained of a sharp pain behind his left knee with ambulation for 4 days. He stated that it was hard to walk. He had to tip toe d/t (due to) pain. He also stated that he had been out of Naproxen for 4 days. The nurse documented no swelling or discoloration, but noted that he was limping. He was referred to the physician.

Physician Encounter
On 6/6/16, the physician saw the patient documenting:

> S: IM said he had been left knee pain when he had a wreck in 1994. Gave medicine and had x-ray of his knee.
> O: IM with chronic knee pain. No fluid in the knee joint. Knee stable.
> A: Chronic knee pain.
> P: Naproxen 500 mg bid.

Medication Administration Records
The patient's June 2016 MARs show that the patient was prescribed simvastatin, amlodipine, Latanoprost, levothyroxine and sertraline. The MARs show that the patient was receiving his medication, except that the patient did not receive Latanoprost. It was last dispensed to the patient on 5/6/16.

Optometry Examination
On 7/13/16, the patient had an optometry examination. The optometrist noted that the patient had not been seen since 2014. The patient complained of blurred vision and noted that he had a congenital eye disorder. His intraocular pressure was borderline =19/18 mm Hg. The patient had abnormal retinal findings suggestive of poorly controlled glaucoma (i.e., cupping and pallor of both optic discs with mottling of the macula OU). The optometrist diagnosed the patient with unstable POAG (primary open angle glaucoma) and ordered Xalatan eye drops for both eyes. He requested follow-up in 2 weeks to check intraocular pressures.

Assessment: This patient has several chronic diseases, including hypothyroidism that were not at goal but he had not been timely seen in chronic disease clinic. The physician noted his chronic diseases and reviewed his abnormal labs, but did not medically evaluate the patient. The patient's chronic disease medications were intermittently ordered, in one case by the psychiatrist. At one point, nurses kept giving prescription medication to the patient, even though the order had expired, which is illegal. This patient was under optometry care, but did not have a requested follow-up, due in February 2015. The physician's evaluation of pain behind his knee did not include evaluation for deep vein thrombosis (DVT).

Patient #8
This 37-year-old man arrived at EMCF in 2011. His medical history includes asthma, seizure disorder, bipolar disorder and antisocial personality disorders (ASPD). His medications are Alvesco, Xopenex, carbamazepine, hydrochlorothiazide, amlodipine, olanzapine and Colace.

Chronic Disease Management
On 8/9/15, a NP saw the patient for chronic disease management. BP=143/83 mm Hg. The NP noted the patient's onset of asthma at age 9 and performed an asthma specific assessment. The NP noted that the patient had nighttime awakening 1-2 times per week. The NP did not assess frequency of inhaler use daily or weekly. Under asthma, the NP noted "I have reviewed

appropriate labs with the patient." The NP noted that the patient suffered from seizure disorder at age 29 following head trauma. The NP did not obtain a history of seizure frequency or when the patient's last seizure occurred. The NP assessed the patient's asthma as being in good and fair control. The NP did not address the patient's seizure disorder. The patient's blood pressure was not at goal. The NP ordered weekly BP monitoring and follow-up in 4 weeks. The NP's note included a statement to "Please renew inhalers." It is unclear who was supposed to renew the inhalers.

Chronic Disease Management
On 9/13/15, the NP saw the patient for follow-up of hypertension. The patient's initial BP=139/107 mm and repeat was 130/90 mm Hg. The NP did not assess the patient's blood pressure control but added Norvasc 5 mg and planned to see the patient in 3 months.

Chronic Disease Management
On 12/12/15, the NP saw the patient. BP=120/80 mm Hg. The NP took a brief neurological and pulmonary ROS. The NP noted that the last seizure was 2-3 weeks prior. The NP noted that there had been no nighttime awakening, but did not assess the frequency of inhaler use. The NP noted that the patient had a history of schizophrenia with visual hallucinations, but denied auditory hallucinations. The NP assessed his hypertension as being in good control, his hyperlipidemia as being in fair control and his asthma as being in good control. The NP did not assess the patient's seizure control. She planned to get his Tegretol level and see the patient in 3 months.

On 2/15/16, labs showed the patient's lithium level was undetectable <0.1, therapeutic=0.6-1.2, however it did not appear that the patient was prescribed lithium.

Lack of Chronic Disease Management
On 3/15/16, the patient was noted as a no-show for his chronic disease appointment and, as of my July 2016 visit, he had not been seen since.

On 4/11/16, labs showed the patient's hyperlipidemia was at goal (LDL=62) and his Tegretol level was undetectable (<0.5, normal=8-12.0).

On 6/24/16, the patient's Dilantin and Tegretol levels were undetectable.

The patient was not prescribed lithium and Dilantin during these time periods.

Assessment: This patient has not had timely chronic disease follow-up. It appears that labs are being ordered for medications not prescribed for the patient.

Patient #9
This 43-year-old man arrived at EMCF on 8/18/15. His medical history includes AIDS, seizure and bipolar disorder. His medications are Truvada, Reyataz, Norvir, Dilantin, carbamazepine and lithium.

Intrasystem Transfer
On 8/18/15, an EMCF nurse medically screened the patient. The nurse did not take the patient's vital signs, note the patient's chronic diseases or what medications the patient was taking. The nurse did not note whether or not medications were transferred with the patient.

Physician Encounter
On 8/18/15, the physician performed a history and physical. The physician noted that the patient had HIV and seizure disorder and that the patient complained of dental problems, vision difficulties and mouth irritation. The physician documented the history and physical using an electronic medical record template. All findings were completely normal including "good dentition." The physician does not have an oto/ophthalmoscope in his office, but documented that the patient had completely normal findings. He documented that he performed a rectal examination with no enlargement of the prostate. The physician's assessment was HIV and he ordered the patient's Dilantin and HIV medications. He documented no other plan for labs and follow-up.

Medication Continuity
The patient's August 2016 MAR shows the patient's medications were started the day after arrival.

Abnormal Labs
On 8/20/15, the patient's HIV viral load was detectable (934 copies, 2.97 log).

Mental Health
On 8/18/15, mental health saw the patient, noting that he had been in prison for one month, to serve a 5-year term.

Sick Call
On 8/30/15, the patient submitted an MSR stating that he wanted to start back on his psychiatric medications. It was received the following day, and on 8/31/15, a mental health provider saw the patient. The patient was depressed but denied suicidal or homicidal ideation. The mental health provider referred the patient to the psychiatrist, and on 9/3/15, the psychiatrist saw the patient and started him on lithium.

Sick Call
On 9/11/15, the patient submitted a MSR complaining of wanting his psychiatric medication times changed. On 9/12/15, it was received. On 9/12/15, a RN saw the patient. BP=140/108 mm Hg and vital signs otherwise normal. Weight=185 lbs. The nurse documented that the patient had dental problems, vision difficulties, was having difficulty urinating and had mouth irritation. The nurse did not assess these problems but referred the patient to mental health. *The nurse did not address the patient's increased blood pressure.*

Lack of Physician Follow-up for Abnormal Lab

On 9/14/16, a phlebotomist documented that nurses reported that the patient didn't come to evening pill call. The phlebotomist noted that he would obtain Dilantin level and follow-up with the physician. On 9/15/15, the patient's Dilantin level was undetectable. On 9/17/15, Dr. Abangan documented his review of the report that the patient was noncompliant with his medication. *The physician took no other action.*

Mental Health Follow-up
On 9/17/15, the patient's lithium level was undetectable. On 9/21/15, the mental health NP met with the patient, who requested moving his lithium to the morning. The NP changed the order with plans to follow-up with labs in one month.

Medication Administration Records
The patient's September 2016 MAR shows that the patient was compliant with HIV medications, but only intermittently compliant with Dilantin and lithium.

Labs
On 10/21/15, the patient's lithium level was almost therapeutic (0.5, therapeutic=0.6 to 1.2).

Sick Call
On 10/21/15, the patient submitted a MSR complaining of jock itch. On 10/22/15, it was received. On 10/22/15, a RN saw the patient.

Medication Administration Records
The patient's October 2016 MAR shows that the patient was compliant with HIV medications but only intermittently compliant with Dilantin. His lithium compliance had improved.

Chronic Disease Management
On 12/2/15, the NP saw the patient for chronic disease management. Weight=171 lbs. Vital signs normal. The NP noted that the patient had HIV and seizure disorder with his last seizure having occurred one year ago. The NP did not document his history of HIV infection, risk factors, opportunistic infections (OI) medication history or compliance. The patient denies CP, shortness of breath, dizziness, palpitation, or blurred vision. No HIV ROS was conducted. The lung exam noted rales in both lungs. The NP did not reference labs showing Dilantin nonadherence or current HIV labs. The NP planned to get labs and see the patient on 3/2/15. The NP did not address the patient's 14-pound weight loss since his arrival (185 to 171 lbs.).

On 12/4/15, the patient's LDL=62, CBC and urinalysis was normal. The patient's lithium level was therapeutic (Lithium level=0.9) reflecting the patient was taking his medication.

Medication Delay
On 12/21/15, the mental health NP added Remeron to the patient's regimen. The medication was started on 12/28/15.

Untimely Review of Labs

On 1/8/16, the patient's CD4[95] count=545 and his HIV viral load was undetectable. On 1/19/16, the NP signed the report.

Abnormal Labs
On 2/26/16, the patient's Dilantin was undetectable.

Chronic Disease Visit
On 3/2/16, the NP saw the patient. Weight=169 lbs. Vital signs normal. There was a repeat of comments in the medical record that are not contemporaneously accurate "Reports HIV+, dental problems, and vision difficulties, Hx (history of) Seizures, last reported 2 months ago, Reporting difficulty urinating. Reports mouth irritation." This comment appears in every chronic disease note. The NP documented that the patient had a 3-month history of intermittent diarrhea. The patient believed it was due to his HIV. The NP did not inquire or describe the patient's pattern and quality of stools, and conducted no constitutional or HIV specific ROS. The patient stopped taking Dilantin because it made him sick. He denied cardiovascular or respiratory problems. The NP documented reviewing appropriate labs with the patient. The NP did not reference the patient's CD4 count or HIV viral load, assess the patient's HIV infection control, or address the patient's diarrhea and 16 lbs. weight loss since his arrival. She did not perform a work-up for his diarrhea or weight loss. The NP documented consulting another NP about potential medication changes.

Abnormal Labs
On 3/9/16, labs showed that the patients lipids were normal LDL=66, Dilantin was undetectable (suggesting that he was not receiving Dilantin) CD4 count was high (CD4=565). His HIV RNA was **detectable** (1.43 logs, normal<1.30) indicating that his HIV disease was not well-controlled.

Therapeutic Labs
On 3/15/16, the patient's lithium level was therapeutic (1.1).

Optometry Exam
On 3/23/16, the patient had an optometry exam that showed decreased vision 20/200 OU (both eyes). IOP's 18 bilaterally. The optometrist called for a one-year follow-up.

Abnormal Labs
On 4/18/16, the patient's lithium level was undetectable.

Abnormal Labs
On 5/12/16, the patient's HIV viral load was detectable at 1.59 logs.

Chronic Disease Management

[95] CD4 count is a lab test that measures immune function and is impaired with HIV infection. . A normal CD4 count is >500 and a low CD4 count is <200 cells and results in opportunistic infections such as pneumonia.

On 5/25/16, the NP saw the patient. Weight=169 lbs. Vital signs normal. The NP documented the same note as in previous visits suggesting that it is cut and pasted and not reflective of what actually took place during the visit The NP did not inquire about the patient's diarrhea or note the patient's weight loss. The NP did not reference labs that showed the patient's HIV viral load was detectable. The NP documented that the patient's HIV disease was in good control with this EMR template definition:

> Degree of Control:
> Good: Patient is asymptomatic, HIV viral load <50,000, CD4 count=>350 cells/mL, body weight is >90% ideal body weight. No active opportunistic infections or malignancies.

This is an outdated definition of disease control for HIV infection and does not reflect the current standard for good control which is that the patient's HIV viral load is undetectable

Abnormal Labs
On 6/27/16, the patient's HIV viral load was detectable at 2.65 logs.

Medication Administration Records
There are blank spaces on the patient's June MAR on 6/17 and 6/20/16, and the MAR states that the patient was a NS (no show) on June 3 and 4 and 21-23.

Assessment: This patient was not seen timely for his worsening HIV infection and the NP has not addressed it. The patient has had dental problems, but a dentist has not seen the patient.

Patient #10
This 29-year-old man arrived at EMCF on 7/30/15. His medical history includes HIV infection, hepatitis and major depression. His medications are Truvada, Prezcobix, Remeron, cyproheptadine and ibuprofen.

On 6/5/15, at his prior facility, the patient had a detectable HIV viral load (3.021 logs, 1050 copies).

Intrasystem Transfer
On 7/30/15, an EMCF nurse did not medically screen the patient.

Physician Encounter for New Arrival
On 7/30/15, the physician saw the patient for a history and physical. The physician noted that the patient had a past medical history of cancer, dental problems and HIV infection, left arm surgery in 2008 and left ear surgery in 2011. The physician did not elaborate on the patient's cancer or surgeries. Weight=140 lbs. BP=145/78 mm Hg, otherwise vital signs WNL. The physician documented a physical examination that was completely normal, including prostate examination and HEENT (head, eyes, ears, nose and throat). The physician's overall assessment was HIV and HCV, but he did not elaborate on the patient's history including date of diagnosis,

risk factors, or opportunistic infections. The physician ordered the patient's medications. He did not address the patient's increased blood pressure.

Medication Delay
The patient's August 2016 MAR shows that he did not receive his HIV medication until the evening of 8/10/16. There are blank spaces on the MAR the first full week and on 8/11, 8/24 and 8/27/16.

Chronic Disease Management
On 8/23/15, the NP saw the patient for chronic disease management. Weight=153 lbs. BP=89/66 and pulse=89/minute. The NP's note included a prepopulated note that the patient had a past medical history of cancer, dental problems and HIV infection, and left arm surgery in 2008 and left ear surgery in 2011. The NP did not elaborate on the patient's cancer or surgeries. The NP documented that the patient stated he was doing "ok" and denied fever, chills, vomiting or cough. The patient sometimes forgot to take his HIV medication. On 6/5/15, his HIV viral load was detectable (VL=1050). The NP did not note the patient's history of HIV diagnosis, risk factors, CD4 nadir (i.e. lowest CD4 count), opportunistic infections, or an adequate HIV ROS. The NP did not address the patient's history of HCV infection or of cancer. The NP planned to order labs (CD4 count and viral load) and follow-up in 3 months. The NP did not review pertinent labs such as serum chemistry or renal function, or the patient's immunization history. On 10/22/15, the patient was offered and refused influenza vaccination. The HIV labs and chronic disease appointment were due on 11/23/15 but this did not take place.

Medication Administration Records Show Medication Nonadherence
The patient's October 2016 MAR shows that the patient was a no show for almost 50% of his HIV medications. There are blank spaces on October 1-6, 16, 30 and 31.

Medication Administration Records Show Medication Nonadherence
The patient's November 2016 MAR shows that the patient was a no-show for approximately 9 doses of antiretroviral therapy. There is no documentation in the record that the nurse notified a provider of the patient's noncompliance.

Physician Sick Call Encounter
On 12/9/15, the physician saw the patient because he requested double portions of food. The patient weighed 124 lbs. Height=65 inches. BP=153/93 mm Hg and vital signs otherwise normal. The physician did not note that the patient had lost almost 30 lbs. since his arrival. The physician did not perform a HIV ROS or an examination of any kind. The provider did not address the patient's history of cancer, noted at his admission history and physical. The physician denied the patient's request for double portions, stating that he did not qualify. He did not address the patient's elevated blood pressure.

Chronic Disease Management
On 12/12/15, the NP saw the patient. Weight=134 lbs. BP=131/84 mm Hg. The prepopulated progress note was still included. The NP noted that the patient had HCV but did not explore the

patient' history or review labs to document that the patient has tested positive for HCV (the patient later tested negative for HCV antibody reflecting that the patient did not have the infection). Yet, with respect to HCV, the NP documented" I have reviewed labs with the patient" when there were no labs showing the patient had HCV. The patient complained of feeling hungry all the time. The NP noted the patient's weight as 131 lbs. The patient denied n/v (nausea and vomiting) and abdominal pain. The NP did not perform a physical examination of any kind or note the fact that the patient had not had ordered labs that were due in November. The NP did not address the fact that the patient had 20+ lbs. weight loss. The NP assessed the patient as being in good control without reference to any clinical information, as no current labs were available since the patient arrived in July 2015. The NP planned to order labs. The provider noted that the patient's BMI (body mass index) was within normal limits but ordered an enhanced diet due to the patient's compromised immune system."

Abnormal Labs
On 12/15/15, the patient's CD4 count=526 and HIV viral load was detectable at 4.44 logs. Renal and liver function tests were normal.

HIV Telemedicine Clinic/Medical Record Error
On 1/20/16, the patient was seen via telemedicine for HIV. However, when scanned into the EMR the note was incomplete and has another patient's note attached to it (Patient #11). Staff rescanned the patient's HIV telemedicine report which was complete.

Abnormal Labs
On 1/26/16, the patient's CD4 count=706 and HIV viral load was detectable (VL=1789 copies).

Medication Administration Records
MARs show that the patient was mostly compliant with HIV medications.

Abnormal Labs
On 2/9/16, the patient's HIV viral load was detectable at 3.14 logs.

HIV Telemedicine
On 2/9/16, the telemedicine HIV NP saw the patient for follow-up. The NP did not perform an HIV disease specific ROS but noted that the patient was doing well on Truvada and boosted his Reyataz, which he had been on for years. The NP noted that the patient denied side effects or other health problems. He reported good adherence to his medications, though his viral load had been persistently high. He agreed to stop his medications to prevent any resistance until a GenoSure[96] was performed. The NP discontinued the patient's HIV medications and ordered an HIV viral load and GenoSure test and other tests which was negative. The note indicated that his influenza immunization was overdue.

[96] A GenoSure is a lab test that is performed to detect viral mutations to HIV medications. It guides the provider to select medications for which there is minimal or no resistance, making the medications more effective against HIV.

On 2/13/16, the patient's GenoSure showed sensitivity to all classes of HIV medications.

Chronic Disease Management
On 3/8/16, another NP saw the patient. Weight=130 lbs. Vital signs WNL. The NP documented that the patient had hepatitis A/B. The NP documented that "He denies any HIV/Immunity symptoms. States that he has been off medications for one month because the telemedicine NP told him she was going to view his lab results before putting him back on HIV medications. He states that she wants to make sure he is not resistant to the medications." The NP noted that "I have reviewed appropriate labs with the patient."

Custody Failed to Escort the Patient for Labs
On 3/11/16, custody failed to bring the patient for labs.

Labs
On 3/16/16, the patient's CD4 count=526. The patient tested negative for HCV antibody. The patient was negative for HBsAg (hepatitis B surface antigen) and positive for hepatitis A and B surface antibodies, meaning the patient had been immunized against hepatitis A and B. The patient did not have active hepatitis A and B infection as documented by the NP.

Medical Records in the Wrong Record
On 4/14/16, a telemedicine note was entered into this patient's record, but was for another patient and indicated that this patient probably does not have HIV infection.

HIV Telemedicine
On 5/10/16, the HIV telemedicine NP saw the patient and noted that he had started a new regimen 3 days prior and was doing well. She noted that on 3/18/16 the patient's viral load was 12,000 copies on no medications. The NP incorrectly believed that the GenoSure test was never drawn but was on 2/18/16. She directed that he continue his medications, check labs in 4 weeks and return for a follow-up appointment in 6 weeks.

Chronic Disease Management
On 6/8/16, the NP saw the patient for chronic disease management. Weight=129 lbs. Vital signs WNL. The provider documented that the patient had HIV and hepatitis A and B infection (which the patient did not have). He denied having any physical problems. The NP did not conduct a HIV ROS and did not note lab results. The patient denied any adverse medication reactions. She assessed the patient's HIV as being in good control which, based upon prior labs was incorrect. She assessed his hepatitis A/B infection as being in good control, but the patient does not have these infections disease. She directed that he continue his current plan of care with a follow-up in 3 months. This is not an appropriate time frame given the patient's HIV disease is not in good control.

Abnormal Labs

On 6/8/16, the patient's HIV viral load was detectable at 2.96. There was no CD4 count conducted.

HIV Telemedicine
On 6/14/16, the HIV telemedicine NP saw the patient for follow-up. The patient reported no HIV symptoms (e.g., fever, chills, night sweats, cough, diarrhea, etc.). No ROS was conducted, except for a discussion of the patient's loss of appetite and weight loss. His weight was then 124 lbs., though his normal weight was 140 lbs. He reported fair adherence to his medications, and she counseled him on compliance.

Assessment: An EMCF nurse did not perform a transfer screening for this patient. The physician performed a history and physical, but did not obtain a past medical history or perform a ROS. He did not inquire about the patient's history of cancer. He documented that the patient had hepatitis C infection, when the patient does not have this disease. He did not note or address the patient's increased blood pressure. The patient did not receive HIV medications timely. When the physician saw and denied the patient's request for double meal portions, he failed to note that the patient had lost 30 pounds and to perform a medical evaluation of any kind. The NPs did not evaluate the patient for medical causes of his weight loss, did not see the patient timely when his HIV viral load became detectable, consistently perform an HIV ROS, note lab values, accurately assess the patient's disease control, or follow-up in accordance with his disease control. One of the NPs also incorrectly interpreted his viral hepatitis serology results, believing that the patient had hepatitis A and B, when in fact labs reflected that he had antibodies against these infections, meaning that he had simply been immunized for hepatitis A and B. This demonstrates a fundamental lack of knowledge about laboratory interpretation of infections commonly found in incarcerated persons. The HIV telemedicine NP also appears to have been unaware of the patient's medication nonadherence, suggesting that the NP did not review the patient's MARs. The NP also noted that the GenoSure test to assess viral drug resistance was never done, but it was in fact completed. Records belonging to other inmates were also found in this patient's record.

Patient #11
This 43-year-old man arrived at EMCF on 3/28/16. His medical history includes bipolar disorder, schizophrenia and possible HIV infection. His medications are Depakote, Haldol and Cogentin.

Prior to transfer to EMCF, a NP at the patient's prior facility saw the patient, who reported that he had HIV infection. The NP ordered an HIV viral load test. On 2/5/16, the HIV antibody test was non-reactive.

HIV Telemedicine
On 2/16/16, at his prior facility, the HIV telemedicine provider saw the patient and noted that he stated he took HIV medications in 1981, but had taken no medication for 30 years. He stated that he was asymptomatic. The provider ordered labs. The patient's CD4 count was

542, his HIV viral load was undetectable, and his HIV Genotyping was indeterminate with respect to identifying resistance mutations that would make medications less effective.

Intrasystem Transfer
On 3/28/16, the patient was transferred to EMCF, and a nurse completed a transfer screening form. Vital signs were normal. Weight=152 lbs. The nurse documented that the patient denied medical and mental health problems, and was taking no medications. However, a 2010 receiving screening form in the patient's file notes that the patient has paranoid schizophrenia and was taking psychotropic medication. The nurse did not note that the patient had a diagnosis of HIV infection that was likely incorrect.

Mental Health
On 3/28/16 at 8:21 pm, mental health saw the patient, given his history of serious mental illness with hospitalization. The NP ordered Haldol, Cogentin and Depakote.

Chronic Disease Management
On 3/30/16, a NP saw the patient and noted his questionable history of HIV infection.[97] The patient reported shortness of breath and weight loss of 30 lbs. in one year. The NP did not explore the patient's shortness of breath and weight loss. The patient weighed 149 lbs. The NP ordered labs and consulted HIV telemedicine.

Chronic disease Management
On 5/17/16, a NP saw the patient who reported that the HIV NP told him he did not have HIV. The NP did not document review of the telemedicine information. This entry was not in the patient's record; I found it scanned into the record of another patient.

Chronic Disease Management
On 6/11/16, another NP reviewed the telemedicine information confirming that the patient did not have HIV infection.

Medication Delays
The patient's April MAR shows that the patient was started on Depakote, Haldol and Cogentin and received the first dose on 4/4/16. The original effective date of the order 3/28/16 was crossed out and 4/2/16 was written over it. The patient's compliance was recorded as being good. The patient was due Haldol on 4/25/16, but did not receive it and refused it on 4/27.

Medication Administration Records
The patient's May 2016 MAR shows blank spaces on 5/12 and 5/17/16. The patient is otherwise documented as receiving his medication.

[97] The patient had a questionable diagnosis of HIV infection, meaning that at some point, the patient or a medical provider believed he had the infection but it had not been clearly established by performing an HIV test. Thus, at the time of transfer there was a questionable history of HIV infection. This was resolved following his transfer when he tested negative for HIV antibody.

Assessment: The intake nurse did not accurately note that the patient had a mental health history, was taking medications, and had a questionable diagnosis of HIV. The NP did not evaluate the patient's symptoms of shortness of breath and weight loss.

Patient #12

This 50-year-old man's medical history includes diabetes, diabetic retinopathy, cataracts, hypertension, asthma, latent tuberculosis infection and bipolar disorder. His medications are Humulin 70/30 and regular aspirin, Lisinopril, hydrochlorothiazide, Alvesco, Xopenex and Tegretol.

On 8/2/14, the EMCF optician noted that the patient had cloudy visual acuity and referred the patient to the ophthalmologist (Dr. Magee). On 11/20/14, Dr. McMillan, another ophthalmologist, saw the patient and noted that he was 6-8 weeks late for his scheduled appointment. The report appeared to be incomplete, as it had no treatment and follow-up recommendations. He had diabetic retinopathy in both eyes and his vision had been worse without glasses in the right eye for the prior three months. He also noted that the patient had partial optic atrophy and ischemic optic neuropathy in both eyes. IOP[98]=20 right eye and 14 left eye. These are findings related to poorly controlled glaucoma.

Chronic Disease Visit by an LPN

On 6/4/15, a LPN saw the patient for chronic disease follow-up but the LPN simply took the patient's blood pressure and there was no other clinical information in the note. The patient's blood pressure was high (BP=154/88 mm Hg). The LPN did not document taking any action to notify a provider.

Eye examination/No Report in the EMR

On 6/9/15, the special service provider, Southern Eye Center, saw the patient and ordered Ciprofloxacin for senile cataract. There is no accompanying report of the ophthalmologist's findings and recommendations.

Chronic Disease Visit by an LPN

On 7/2/15, a LPN saw the patient for chronic disease follow-up but the LPN simply took the patient's blood pressure. BP=132/87 mm Hg.

Abnormal Lab

On 7/25/15, labs showed the patient's diabetes was very poorly controlled (HbA1c=14.0%).

Chronic Disease Visit Cancelled Four Times in 4.5 months

On 8/9/15, the patient was scheduled for chronic care but was not seen. The header note for the visit said "IM Refused and Security." It is unclear what this means.

[98] IOP=Intraocular pressure. IOP is used to test patients for glaucoma.

On 9/21/15, the patient was scheduled for chronic care but was not seen due to No Show.

On 12/21/15, the patient was scheduled for chronic care but was not seen due to No Show.

On 12/21/15, the patient was scheduled for chronic care but was not seen due to No Show.

Chronic Disease Visit Patient Not Seen in Accordance with Disease Control
On 1/31/16, a NP saw the patient for follow-up. Weight=230 lbs. BP=142/79 mm Hg. The NP did not perform a specific diabetes (DM) or cardiovascular (CV) ROS, and only noted "no CV symptoms." He denied asthma symptoms. The patient told the provider that he had "floaters" in both eyes as well as cataracts. He was supposed to have surgery on his eyes in Hattiesburg but the new company took over and he has not had surgery. The patient stated that he took all medications as prescribed. The NP noted that she "reviewed labs with the patient," that the patient had Type 1 diabetes, and that he refused a foot exam. She did not reference the patient's lab results. She noted that the patient's diabetes was in poor control and worsening, and his hypertension was in fair control. She did not assess his LDL. She documented that he would be seen again in 3 months. She documented no review or plan related for his diabetic retinopathy and senile cataract.

On 1/29/16, the patient's lithium level was <0.1.

Optometry/Delayed referral to ophthalmology
On 3/2/16, EMCF optometry saw the patient and noted his visual acuity was 20/200 OU (both eyes) with no improvement with refraction. IOP=18/16 mm. He referred the patient to Southern Eye Center, but as of my July 2016 visit, this had not taken place.

Chronic Disease Management
On 4/3/16, another NP saw the patient for chronic disease management. The NP performed no CV or DM review of systems (ROS) of any kind. BP=120/80 mm Hg. Weight 228 lbs. The NP noted that his hypertension was stable at 122/89 mm Hg, but that she planned to increase his Lisinopril to 30 mg daily. The NP documented that the patient's diabetes was not controlled as evidenced by a last HbA1c=8.4% (however I was unable to locate the lab report in the record). The NP planned to repeat labs and adjust medications afterwards. She noted that his last ophthalmology appointment was less than 3 months ago and he had a referral to SEC.

Labs
On 4/15/16, the patient's HbA1c=7.6%. Renal and liver function tests (LFT) were normal.

Chronic Disease Clinic Visit Not Performed Due to Custody
On 6/29/16, the patient was scheduled for a chronic care clinic visit, but not seen due to there being no escort.

On 7/11/16, the patient was scheduled for a chronic care clinic visit, but not seen due to there being no escort.

Assessment: In July 2015, labs showed the patient's diabetes was very poorly controlled, but the patient was not seen timely for evaluation and treatment. From August to December 2015, four chronic disease appointments were cancelled. When NPs saw the patient, they did not perform chronic disease visits in accordance with the American Diabetes Guidelines, including performing diabetic ROS, obtaining microalbumin levels, immunizations, lipids, etc. The patient has not had timely care for his diabetic retinopathy. Ophthalmology specialty notes with the patient's diagnosis, treatment plan and frequency of follow-up are not scanned into the EMR. The optometrist's 3/2/16 referral had not taken place more than four months after the referral was made.

Patient #13

This 38-year-old man transferred to EMCF in early 2011. His medical history included hypertension, diabetes, glaucoma gastroesophageal reflux disease (GERD) and psychotic disorder. His medications are Humulin 70/30 and Humulin Regular, Lopid, Xalatan and mirtazapine. I reviewed this patient's record in 2014, as well. His care, poor then, has not improved since my last report.

Lack of Follow-up of Ophthalmological Recommendations/Incomplete Medical Records

On 5/27/15, the special services provider, Jackson Eye Institute, ordered Lumigan 0.01% for the patient. There was no accompanying consult note found in the record, and the patient's June 2015 MAR shows he did not receive the medication. He was also prescribed Brimonidine at that time.

Failure to Order Glaucoma Medications

On 6/8/15, Jackson Eye Institute saw the patient, who complained of burning pain, and sensitivity to light, and that he never received his eye drops. IOP=19/16 mm. Visual acuity (VA) =20/25 and 20/25. It does not appear that a retinal exam was performed. Another prescription for Lumigan was sent to the facility.

Lack of Follow-up of Ophthalmological Recommendations/Incomplete Medical Records

On 6/22/15, Jackson Eye Institute sent a prescription for Lumigan and Zylet one drop twice daily to the facility. There is no accompanying consult note.

Abnormal Lab Test

On 7/10/15, labs showed that the patient's diabetes was poorly controlled (HbA1c=12.3%).

LPN Chronic Disease Visit

On 7/13/15, a LPN saw the patient to measure his vital signs. BP=142/81 mm Hg.

On 8/10/15, a LPN saw the patient to measure his vital signs. BP=129/81 mm Hg.

Medication Discontinuity
The patient's July 2015 MAR shows that he was not issued Brimonidine.

Medication Administration Records
On 8/10/15, the patient was issued Brimonidine and Lumigan.

Medication Discontinuity
The patient's September 2015 MAR shows the patient was not issued Brimonidine and Lumigan.

Ophthalmology Visit/Incomplete Medical Records
On 8/26/15, ophthalmology prescribed the patient Brimonidine, Lumigan and artificial tears. There is no accompanying consult note.

Chronic Disease Visit Did Not Take Place
On 10/11/15, a note documented that the patient refused chronic care.

Abnormal Labs
On 10/21/15, the patient's diabetes (HbA1c=12.6%, goal≤7%) and lipid (LDL=138, goal≤100) labs were abnormal. His renal and liver functions tests were normal.

Chronic Disease Visit
On 10/25/15, a NP saw the patient for follow-up, his first visit since the July 2015 labs. The NP documented that the patient denied headache, dizziness and slurred speech, and reported compliance with his medications. The NP did not conduct a CV or DM ROS. The NP wrote, "I have reviewed labs with the patient." Weight=227 and BP=120/89 mm Hg. Foot exam normal. HbA1c=12.6%. The NP documented that the patient's hyperlipidemia control was fair and improved, and his endocrine status was poor and worse. The NP ordered Novolin 70/30 45 units in the morning and 45 units in the evening. She ordered a repeat of the A1C lab and a follow-up visit in 3 months.

On 1/6/16, the above prescription was renewed. The patient's triglycerides were very elevated (TG=331, normal≤150), increasing the patient's risk of pancreatitis.

Chronic Disease Visit
On 1/26/16, a different NP saw the patient for follow-up. She documented that the patient had Type 1 diabetes. She conducted no CV or DM ROS, and recorded that he "denies CV symptoms." She noted that the patient had decreased foot sensation in both feet, that he Reported compliance with all of his medications, but then also noted that he missed his glucose testing and insulin in the morning because the nurse would come at 4 am. She wrote that he stated he had diarrhea sometimes, and that she "reviewed all labs with the patient." Weight=234 and BP=124/84 mm Hg. Foot exam normal. She did not reference his recent labs. The NP assessed the patient's hypertension as being in good control, did not assess his

hyperlipidemia, and assessed the patient's diabetes to be in poor control but did not change his treatment plan. She planned to receive his labs and see the patient in 3 months.

No Follow-up after Abnormal Labs
On 1/29/16, labs showed that the patient's lipids were at goal LDL=82. On 2/2/16, diabetes labs showed that the patient's diabetes was still poorly controlled (HbA1c=12.8%). The patient was not seen timely after these lab reports.

On 3/16/16, the EMCF optometrist saw the patient. IOP=18 mm right eye and 17 mm left eye. The optometrist assessed the patient with stable primary open angle glaucoma (POAG) and referred the patient back to the ophthalmologist.

Missed Medications
The patient's April 2016 MAR shows the patient did not receive Latanoprost or Brimonidine and missed many doses of his morning insulin, Lisinopril, metformin and gemfibrozil.

Abnormal Labs
On 4/27/16, labs showed that the patient's TG=326 and LDL=90 and HbA1c=12.0%

Chronic Disease Management
On 4/25/16, the NP saw the patient for follow-up. BP=130/83 mm Hg. The majority of the NP's notes are the same in content and simply note that the patient had not had any ER visits and takes all of his medications as prescribed. She did not conduct a CV or diabetes ROS. She assessed the patient's hypertension as being in good control but worsening and his diabetes as in poor control. The NP did not change the patient's treatment plan and did not assess his hypertriglyceridemia.

As of 7/15/16, the patient had not been seen for chronic disease follow-up.

Medication Administration Record Shows Missed Medications and Blank Spaces
The patient's May 2016 MAR shows that the patient did not receive his Brimonidine on 5/3, 6, 7, 8, 11, 12, 26-31. The patient was not given his "keep on person" Latanoprost that month. There are also blank spaces for the patient's Metformin on 5/7, 5/16 and 5/30.

Medication Administration Record Shows Missed Medications
The patient's June MAR shows the patient was not given Latanoprost that month.

Ophthalmology Follow-up
On 5/20/16, the patient went to the Jackson Eye Institute, which reordered the patient's glaucoma regimen.

Assessment: This patient's diabetes and hyperlipidemia were in poor control, but the NPs did not change the patient's treatment regimen in a timely manner. At the time of my July 2016 visit, these diseases remained in poor control. The NPs do not coordinate labs so they are

available prior to his chronic disease visits, and did not see the patient timely when his labs showed that the patient's chronic diseases remained in poor control. A NP determined that the patient had Type 1 diabetes, but the basis for this classification was unclear, as the patient was obese, which is more typical of Type 2 diabetes. One NP routinely documented that the patient took all medications as prescribed, which is not consistent with the information on the MARs. I did not find ophthalmology consult notes in the patient's record, but documentation shows that the patient did not consistently receive his glaucoma medications. Dr. Abangan was not involved in the care of the patient's chronic diseases.

Patient #14

This 69-year-old man arrived at EMCF in 2009. His medical history includes hypertension, hyperlipidemia, COPD, latent tuberculosis infection, Parkinson's, major depressive and generalized anxiety disorder. His medications are triamterene,-HCTZ, atenolol, albuterol sulfate nebulizer, carbidopa-levodopa, aspirin, Prilosec and divalproex sodium and levothyroxine.

Chronic Disease Management

The patient had been seen for chronic disease management by a provider on 12/15/15, 3/9/16 and 6/2/16. At the 6/2/16 visit, the NP performed no meaningful neurological, pulmonary or CV ROS.

Dental Sick Call

On 11/3/15 and 11/4/15, the patient was listed on the sick call log for a broken tooth and dental pain. He was not seen.

On 4/6/16, the patient submitted a MSR complaining of a tooth ache and his face being extremely swollen. A nurse did not see the patient. On 4/7/16, a staff person wrote that the patient was not seen by the physician, and the patient was rescheduled for 4/14/16. On 4/14/16, the dentist documented that the patient had a nonrestorable tooth due to abscess. The patient granted consent for extraction. The patient received Ibuprofen but no antibiotics and no follow-up. The patient had not been seen since as of my July 2016 visit.

Assessment: The patient did not have timely access to dental care. The patient was not treated with antibiotics despite having a dental abscess. With respect to the patient's chronic disease management, the NP did not perform an adequate assessment by performing a review of systems for each disease.

Patient #15

This 28-year-old man arrived at EMCF on 8/14/15. His medical history includes bipolar disorder. As of my July 2016 visit, he was taking no medications.

Intrasystem Transfer

On 8/14/15, an EMCF nurse screened the patient. The nurse noted the patient had a history of mental health treatment. The nurse did not list any medications. Vital signs were normal. The

nurse scheduled the patient to see a physician in 4 days. There was no chronic care clinic enrollment.

On 10/29/15, the patient submitted a MSR complaining that the right side of his teeth was aching, even when he brushed them, and was getting worse every day. It was received on 10/30/15. On 11/12/15, a dentist documented that the patient pointed to his front teeth, top and bottom and that "The patient's teeth were too sensitive to examine today." The dentist gave him Peridex and Ibuprofen and rescheduled the patient for a later date. The dentist noted "He is to return when not hurting."

On 11/17/15, the patient submitted another MSR indicating that his teeth were hurting. A nurse did not see the patient. On 11/22/15, a dentist saw the patient and noted excessive calculus (i.e. dental plaque) buildup. He hand scaled the lower anterior teeth to remove the calculus. He planned to return to dental for cleaning. The patient had not been seen again as of my July 2016 visit.

The patient was listed on the sick call log on 12/28 and 12/29/15 with dental pain. There is no documentation in the record that the patient was seen. Indeed, the patient had not been seen again as of my July 2016 visit.

Assessment: The patient has not had timely access to dental care.

Patient #16

This 28-year-old man arrived at EMCF on 6/10/15. His medical history includes hypertension. His medications include are hydrochlorothiazide.

Intrasystem Transfer

The patient transferred to EMCF on 6/2/15 and a nurse completed a transfer screening. The patient appears to have then transferred to another facility, and transferred back to EMCF on 6/10/15, but a nurse did not medically screen the patient. A physician performed a history and physical the day of his arrival, documenting a complete examination including a rectal exam. The patient's BP=144/96 mm Hg, but the physician did not address the patient's increased blood pressure by ordering blood pressure monitoring. The physician did not obtain the patients' past medical history or perform a ROS.

Dental Care

This patient was listed on the sick call log on 12/25/15 as needing his tooth pulled. On 12/25/15, a nurse saw the patient for dental pain that he rated 8 of 10 in severity. The patient had a hole in one of his teeth. The nurse gave the patient five days of ibuprofen but did not document a referral to dental.

On 2/25/16, dental saw the patient and noted gross decay to one of his teeth. , and carious lesion to pulp (center of the tooth). He removed most of the decay and placed a temporary

filling until the tooth could be extracted. The patient received no ibuprofen or antibiotics. On 2/27/16, another dentist extracted the tooth. The patient received no Ibuprofen or antibiotics.

Chronic Disease Management
On 1/28/16, the patient's blood pressure was elevated (BP=156/91 mm Hg). There was no documented action (i.e. referral to a medical provider) associated with this high blood pressure measurement.

On 2/13/16, a nurse referred the patient to a NP for dizziness and lightheadedness. Temp=99.8 Fahrenheit. BP=178/101 mm Hg. The patient had a previous elevated blood pressure of 158/90 mm Hg. The NP treated the patient with clonidine and added a diuretic (hydrochlorothiazide).

Chronic Disease Management
On 4/27/16, the NP saw the patient for chronic disease management. BP=133/88 mm Hg. The patient was taking HTCZ.

Assessment: With respect to the patient's medical care, the physician did not perform an adequate history and physical examination by obtaining the patient's past medical history or performing a review of systems related to his chronic disease. The patient was not referred to a provider timely for his poorly controlled hypertension and when the NP saw the patient the follow-up interval was not in accordance with the patient's poor hypertension control. The patient did not have timely access to dental care.

Patient #17
This 28-year-old man arrived at EMCF on 6/17/15. His medical history includes cellulitis. His medications include Bactrim.

On 10/14/15, the patient submitted a MSR for a cavity. On 10/15/15, a nurse saw the patient and referred the patient to a dentist.

On 11/30/15, dental saw the patient for a 2-year dental exam and cleaning. The patient's cavity was not addressed.

On 12/15/15, the patient submitted a MSR for dental pain. On 12/18/15, a nurse saw the patient and referred him to dental.[99]

On 12/24/15, the patient submitted a MSR for dental pain. On 12/25/15, a nurse saw the patient. The examination was not adequate. The nurse referred the patient to the dentist. On

[99] The dates may have been 12/5/15 for the patient's submission of the MSR and 12/8/15 for the nurse seeing the patient.

12/24/15, the dentist saw the patient and offered to replace a broken filling, but the patient requested that it be extracted. The patient was given Ibuprofen.

On 1/17/16, the patient submitted a MSR complaining of a toothache. On 1/18/16, the form was received and a nurse saw the patient. The patient had a broken tooth on his lower left gum and wanted it pulled. He rated his pain a 4 out of 5 in severity. He was referred to the dentist.

On 1/18/16, the patient submitted a MSR complaining of a toothache. On 1/20/16, the form was received and a nurse saw the patient. The nurse referred the patient to the dentist.

On 1/28/16, dental saw the patient and extracted his tooth.

Assessment: The patient first reported dental pain in mid-December and was initially seen by the dentist on 12/24/15, but was not timely seen for definitive care for his broken tooth. He submitted a medical request two more times before his dental pain was resolved.

Patient #18

This 42-year-old man arrived at EMCF on 9/4/15. His medical history includes hypertension and bipolar disorder. He was not taking medication as of my July 2016 visit.

Intrasystem Transfer

On 9/4/15, an EMCF nurse screened the patient. The patient had hypertension and a mental health history. BP=134/92 mm Hg. The nurse at the prior facility who completed the patient's transfer form noted that the patient had hypertension. The EMCF nurse did not note his hypertension or whether any medications transferred with the inmate.

On 9/4/15, a medical provider ordered hydrochlorothiazide and Risperdal for the patient.

On 9/8/15, the patient was involved in a stabbing incident. His blood pressure was elevated (BP=161/99 mm Hg).

Physician Encounter

On 9/9/15, the physician saw the patient and performed a history and physical devoid of any medical history, diagnoses or plan.

On 9/9/15, the patient's blood pressure was mildly elevated (BP=134/96 mm Hg).

On 12/8/15, the patient's blood pressure was moderately elevated (BP=158/97 mm Hg).

On 6/2/16, the patient's diastolic blood pressure was moderately elevated BP=132/100 mm Hg.

Medication Administration Records Show Patient Not Receiving Chronic Disease Medications

The patient's October and November 2015 MARs show the patient was not taking either of his medications. MAR documentation indicates that the patient was a No Show and did not refuse medications.

Medication Discontinuity and Lack of Chronic Disease Follow-up
The patient's order for blood pressure medication (HCTZ) expired on 3/4/16 and was not renewed. As of my July 2016 visit, he had never been seen in a chronic care clinic.

Dental Care
On 12/8/15, the patient was listed on the sick call log with dental pain. A nurse did not see the patient. On 12/17/15, the dentist saw the patient.

Assessment: The physician performed a history and physical devoid of any pertinent past medical history or ROS and did not enroll the patient into the chronic disease program. The patient's hypertension was poorly controlled and his medications had expired, which went unnoticed by staff. With respect to dental care, a nurse did not screen the patient for severity of pain and potential infection and the patient was not seen timely by dental staff.

Patient #19
On 7/6/16, this mentally ill patient was placed in the Intake Unit after starting a fire in his infirmary cell. This area is not staffed by health care or custody staff. The medical observation form showed that medical staff made rounds on 7/6, 7/7, 7/11 and 7/12/16. Staff did not make rounds on 7/8, 7/9 or 7/10/16.

Assessment: This patient was not within the sight or sound of medical or custody staff. Medical staff did not perform daily rounds and the patient has no means to notify staff in the event of an emergency. This places the patient at risk of harm.

Patient #20
During our tour of the infirmary, we noted that this patient had been housed in the infirmary since 4/22/16 due to poor vision. According to Mr. Little, EMCF's Health Services Administrator, this patient was not able to have his property and received no programming.

Assessment: Placing a vision-impaired patient in the infirmary with no programming is the equivalent of being in segregation and is punitive.

Exhibit 1

Madeleine LaMarre, MN, FNP-BC
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Rio Rancho, NM 87124-1709
(404) 694-0655
mlamarre55@gmail.com

EDUCATION

Master of Nursing. Emory University, Atlanta, Georgia. March 1982.
Bachelor of Science in Nursing. Russell Sage College, Troy, New York. May 1977.

EXPERIENCE

Correctional Health Care Consultant **May 2003 - Present**
Madeleine LaMarre PC
Provides technical assistance to correctional agencies regarding correctional health care delivery systems. Assists agencies with the development of health care policies, protocols, training, and clinical auditing processes to ensure compliance with generally accepted professional standards. Serves as an independent correctional expert monitoring compliance with settlement agreements and/or remedial plans in state and county correctional agencies (see Appointments). Also serves in a consulting role to assist health care providers in achieving patient/client goals with emphasis on patients with acute, chronic, and infectious diseases.

Family Nurse Practitioner **January 2005 to April 2007**
Medical College of Georgia
Provided clinical care to women with HIV infection at Georgia Department of Corrections facilities. Works in collaboration with an infectious disease trained physician to provide HIV consultation services regarding HIV infected patients to physicians, nurse practitioners, nurses and other health care providers.

Statewide Clinical Services Manager **January 1995 - December 2004**
Georgia Department of Corrections
Assessed, monitored, and evaluated the quality of health services within state correctional facilities. Assisted in the development of health care policy, clinical guidelines and standards for the agency. Conducted site visits to correctional facilities to provide consultation and technical assistance to health care providers in meeting clinical, professional standards, and state law. Served in a consulting role to assist health care providers in achieving patient/client goals with emphasis on patients with acute, chronic, and infectious diseases. Monitored the performance of contract vendors by conducting health care evaluations at correctional facilities. Collaborated with agencies to obtain grant monies and resources to advance the goals and objectives of health service delivery. Coordinated responses to communicable disease outbreaks with the Georgia Department of Human Resources (DHR) and Centers for Disease Control and Prevention (CDC). Represented the Department of Corrections at interagency task forces and planning councils.

Nursing Director/Nurse Practitioner **November 1984-December 1994**
Georgia Department of Corrections
Provided expert clinical assistance in the planning, implementation and evaluation of nursing services within the state correctional system. Coordinated the development of statewide policies and procedures for nursing services. Evaluated nursing practice at the approximately 65 state institutions, transitional and detention centers. Provided technical assistance in meeting professional standards, state, and federal laws. Provided primary care services to offender/clients at correctional institutions, exercising skills of assessment, diagnosis, and plans of care in collaboration with the health care team. Directly supervised two professional nursing staff and an epidemiologist to implement nursing and public health programs. Coordinated the development of statewide policies and procedures related to the diagnosis and management of offenders with HIV infection, tuberculosis, and chronic illnesses. Provided training regarding clinical and administrative topics. Represented the agency through participation in various interagency task forces and planning councils.

Family Nurse Practitioner **March 1982 - October 1984**
Atlanta Advancement Center
Georgia Department of Corrections
Administrator of the health clinic and primary health care provider to the adult male population at the transitional center. Exercised skills of patient assessment, diagnosis, and implementation of therapeutic measures in collaboration with a physician consultant and other appropriate health care personnel. Coordinated health care referrals and consultations for all residents. Supervised clinical experiences for nurse practitioner students from local universities. Collaborated closely with the superintendent of the transitional center to ensure organized, systematic operation of the clinic while maintaining quality standards of health care.

Family Medicine, Philip Cohen, M.D., Marietta Georgia
Collaborated with Philip Cohen M.D. in a private practice sitting in the management of acute and chronic illness in adults and children. Actively encouraged individual responsibility for personal health, and strategies to promote health and prevent illness among clients.

Lawrenceville Regional Youth Development Center, Lawrenceville Georgia
Clinician/administrator of health clinic for a 300-bed capacity adolescent detention facility. Provided physical examination services and evaluation of acute illness in collaboration with the physician consultant. Provided phone consultation for the center. Referred to local agencies when appropriate.

Staff Nurse, Level II **October 1978-September 1980**
Emory University Hospital
Developed expertise in the pre- and post-operative care of adults requiring cardiovascular surgery. Provided teaching and counseling prior to discharge to the home setting. Oriented new staff to the cardiovascular unit. Frequently acted as charge nurse of the unit.

EXPERT WITNESS

I have testified as a health care expert in court or by deposition, or provided an opinion in the following cases:

Reed v. Cook County et al. Court No: 03 L 010075, September 2006 (Deposition). Plaintiff expert.

Don Foster and Vincent Williams v. Midwest Security Housing LLC, et al. October 2006 (Deposition). Plaintiff expert.

Jeffery Presley, et al. v. Christopher Epps, et al. United States District Court for the Northern District of Mississippi, Greenville Division. No.4-05CV148-M-D. Supplemental Consent Decree for Medical Care. April 16, 2007. Plaintiff Expert.

Flynn v. Doyle. United States District Court for the Eastern District of Wisconsin, No. 06-CV-537-RTR. April 2008 (Deposition). Plaintiff expert.

Emily Rice v. Denver Health Medical Center. 2008. Defendant expert.

Heino v. Outagamie County. 2009. Plaintiff expert.

Kimberly Brown et al. v. CCA et al. USDC Western District Court for the Western District of Tennessee. 2011. Defendant expert.

Michael Campbell v. Boyd County et al., USDC Eastern District of Kentucky. Case No. 10-00062-HRW. January 2012. (Deposition) Plaintiff Expert.

Joyce Christie, Individually, and On Behalf of the Estate and Next of Kin of Nicholas T. Christie, Deceased vs. Lee County Sheriff's Office, et al. United States District Court, Middle District of Florida. Case No. 2:10-CV-420-FTM-36-DNF. March 2012 (Deposition). Plaintiff Expert.

Louis Henderson et al. v. Kim Thomas et al. United States District Court for the Middle District of Alabama, Northern Division. Civil Action No.: 2:11-CV—00224. 2011 (Deposition and Trial). Plaintiff Expert.

Gregory Johnson et al. v. City of Philadelphia and Prison Health Services, Inc. United States District Court, Eastern District of Pennsylvania .Case No. 09-6097. July 2012 (Videotaped testimony for trial). Plaintiff Expert.

Ray E. Hamilton v. Pike County Kentucky et al. Case No. 02:11-cv-0009-ARY. 2012. Plaintiff Expert.

Cindy Jimenez et al. v. Hopkins County, Kentucky, Joe Blue, Southern Health Partners, Inc., et al. United States District Court for the Western District of Kentucky. Owensboro Division. Civil Action No. 4:11cv-33 M. November 2012 (Deposition). Plaintiff Expert.

Jermaine Dockery et al. v. Christopher Epps et al. United States District Court for the Southern District of Mississippi. Jackson Division. Civil Action No. 3:13cv326-TSL-JMR. 2013. Plaintiff Expert.

C.B., et al. v. Walnut Grove Correctional Authority et al. Consent Decree. The United States District Court for the Southern District of Mississippi Jackson Division. Civil Action No. 3:10 cv663. March 26, 2012. Plaintiff Expert.

Estate of Rachel M. Hammers et al., vs. Douglas County Board of Commissioners et al. No.2:14-CV-02188-JTM-KMH. February 2015. Plaintiff Expert. February 2015 (Deposition).

Diana Rice, Administratrix of the Estate of Ronald Gaunce, Deceased, and Next of Friend of Mr. Gaunce Minor Child, S.C.G. v. Montgomery County, Kentucky et al. United States District Court, Eastern District of Kentucky At Lexington. Civil Action No: 5:14-CV-181-KKC. February 2015. Plaintiff Expert.

In the Matter of Mark Burden v. Grant County Fiscal Court, Grant County, Kentucky, et al. United States District Court, Eastern District of Kentucky, Northern Vision at Covington. Case No. 2:14-CV—54-WOB-JGW. March 2015. Plaintiff Expert.

Michael Faziani v. Sierra Board of County Commissioners, Roxanna Cardenas, Christopher Rees, Curtis Cherry, Leonard Stufflebean, Joshua Corley, and Virgil Eaton. In the United States District Court For the District of New Mexico. Case No. CIV 14-00592 MV/CG. June 2015. Plaintiff Expert.

Charlotte Diana Winkler, Administratrix of the Estate of Brandon Clint Hacker, Deceased vs. Madison County, Kentucky, Doug Thomas, Advanced Correctional Health Care, Inc., Nadir Al-Shami MD, et al. United States District Court. Eastern District of Kentucky. Central Division Lexington. Civil Action No. 5:15-CV-45-KKC. November 2015. Plaintiff Expert.

Lewis et al. v. Cain et al. United States District Court. Middle District of Louisiana. Civil Action No. 15-318-BAJ-RLB. December 2016. (Deposition). Plaintiff Expert.

CORRECTIONAL HEALTH CARE EXPERT

I have been qualified in State and Federal Courts as a medical/nursing/correctional health care expert, assisting in the monitoring of remedial plans or settlement agreements in the following cases:

Plata v. Brown, USDC/Northern District of California, Case No. C-01-1351, TEH, re: Prisoner medical care in the California Department of Corrections and Rehabilitation (CDCR).

Farrell v. Cate, Superior Court of California, Case No. RG03079344, re: Medical care in the Division of Juvenile Justice, CDCR.

Fussell v. Wilkinson, USDC/Southern District of Ohio, Western Division, Case No. C-1-03-704.

United States Department of Justice and the State of Delaware Memorandum of Agreement to Monitor 4 Delaware Correctional Facilities.

United States Department of Justice versus Dallas County Jail. Memorandum of Agreement. Civil No.

307CV 1559-N.

United States Department of Justice versus Cook County Jail. Memorandum of Agreement. Civil No. 10 C 2946.

Colon et al. v Passaic County et al. Memoranda of Agreement. Case No. 2:08-cv-04439.

CONSULTATION SERVICES

Provided consultation services regarding correctional health care delivery to the following agencies:

- US Territory of the Virgin Islands-August 2007
- Department of Homeland Security-January 2007 to present
- DeKalb County Jail. Atlanta, Georgia. January-April 2002.
- Fulton County Jail. Atlanta, Georgia. April-May 2000.
- Minnesota Department of Corrections. January 2000.
- Vermont Department of Corrections. January 1997.
- District of Columbia Detention Facility. June 1996.

PROFESSIONAL MEMBERSHIPS

- American Association of Nurse Practitioners #9702180 Expires 6/2017
- Academy of Correctional Health Professionals Expires 1/2017
- American Nurses Association #03176051 Expires 6/2017
- Georgia Nurses Association Expires 6/2017
- New Mexico Nurses Association #03176051 Expires 6/2017

CERTIFICATIONS

Family Nurse Practitioner. American Nurses Credentialing Center. January 1, 2013-December 31, 2017. #0035518

Registered Nurse/Nurse Practitioner. State of Georgia. # RN053008. Exp. 1/31/2020.

Certified Nurse Practitioner. State of New Mexico. CNP-#02639. 6/30/2018.

Registered Nurse. State of New Mexico #80842. Expires 6/30/2018. Multistate Compact.

Registered Nurse. State of New York. #298832. 10/21/1977. Inactive.

National Provider Identifier No. 1851372452.

PROFESSIONAL ACTIVITIES

Appointments:

Editorial Advisory Board. Correctional Health Care Report. Civic Research Institute. January 2014 to present.

Advisory Board Member for Plata v. Brown. Appointed by Judge Thelton Henderson May 2010-2012

Affiliate Faculty. Nell Hodgson Woodruff School of Nursing. Emory University. May 2002-2007 and September 2009 to August 2012.

National Prison Rape Elimination Commission. Medical and Mental Health Standards Committee Member. 2007-2009.

Federal Court Appointed Expert for Plata v. Schwarzenegger. United States District Court-Northern District of California. June 2002-Present.

Publication Advisory Board. Correctional Health Care: Guidelines for the Management of an Adequate Delivery System. National Commission on Correctional Health Care. 2001- 2002.

Reviewer for the American Journal of Public Health-2001.

NIDA-Emory Men's Prison Initiative Advisory Committee-1999.

Distinguished Faculty in Correctional HIV Medical Services. Bristol-Myers Squibb. 1998-present.

Advisory Board Member-Center for Crime, Communities, and Culture. Open Society Institute. 1996-2000.

Human Investigations Committee, Emory University School of Medicine. 1997-2000.

Clinical Associate Faculty. Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA. 1984-1991.

Chairperson. Institutional Review Board. AIDS Research Consortium of Atlanta. October 1991-September 1994.

Editorial Advisory Board. Correctional Health Care Management. July 1993-94.

Georgia Statewide HIV Prevention Community Planning Council 1994-95.

Publications:

Jafa, K, McElroy P, Fitzpatrick, L. Borkowf CB, MacGowan R. et al (2009) HIV Transmission in a State Prison System 1988-2005. *PLoS ONE* 4 (5): e5416. doi:10.137/journal.pone.0005416

Centers for Disease Control and Prevention. HIV Testing Implementation Guidance for Correctional Settings. Co-Author. January 2009.

LaMarre, M. Point-Counterpoint: What are the Implications of the Study Conducted in the Georgia Department of Corrections For HIV Prevention in Prisons? Infectious Diseases in Corrections Report. May 2006. Vol. 9, Issue 5.

CDC. "HIV Transmission among Male Inmates in a State Prison System-Georgia 1992-2005." *Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report,* April 21, 2006, Vol. 55, No 15. Reported by Taussig, J., Shouse, L., LaMarre, M., et al.

Puisis, Michael. Associate Editor, Madeleine LaMarre. *Clinical Practice in Correctional Medicine.* Second Edition. Mosby. 2006

LaMarre, Madeleine. "Nursing Role and Practice in Correctional Facilities" in *Clinical Practice in Correctional Medicine*. Second Edition. Puisis, M. Mosby, 2006.

Khan, A., Simard, E., Bower, W., Wurtzel, H., Khristova, M., Wagner, K., Arnold, K., Nainan, O., LaMarre, M., Bell, B. "Ongoing Transmission of Hepatitis B Virus Infection among Inmates at a State Correctional Facility." *American Journal of Public Health,* Vol. 95, No 10. October 2005.

DeRavello, L., Brantley, M., LaMarre, M. Qayad, M., Aubert, H. and Beck-Saug, C. "Sexually Transmitted Infections and Other Health Conditions of Women Entering Prison in Georgia 1998-1999." *Sexually Transmitted Diseases*. Vol. 32, April 2005. pg. 247-251.

Arnold, K., LaMarre, M., Taussig, J. et al. "Transmission of Hepatitis B Virus in Correctional Facilities-Georgia, January 1999-June 2002." *Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report,* August 6, 2004, Vol. 53, No 30.

Wootton, S., Arnold, K., Hill, H., McAllister, S., Ray, M., MS, Kellum, M., BS, LaMarre, M., Lane, M., Chaitram, J., Lance-Parker, S., DVM, Kuehnert, M. "Interventions to Reduce the Incidence of Methicillin Resistant Staphylococcus Aureas (MRSA) in a Georgia Correctional Facility." *Infection Control and Hospital Epidemiology*, Vol. 25, No. 5. May 2004.

Tobin-D'Angelo, M., LaMarre, M., Lane, M.E. "MRSA Outbreak in a State Prison: Implications for Prevention and Control." Oral Presentation. 131st American Public Health Association Meeting. November 15-19, 2003.

W. Bower, A. Khan, E. Simard, M. Khristova2, H. Wurtzel, K. Arnold, M. LaMarre, O. Nainan, B. Bell.

"Molecular Epidemiology of Hepatitis B Virus Transmission in a United States Correctional Facility." ISDA Abstract.

Barrett, KL. Braithwaite, R., Krane, KM, LaMarre, M. Creagh, T., Moore, W. "Women's Transition to Health and Healing: HIV Correctional Health Care/Education/Transition (CET) Team." Poster and Oral Presentation. ACA Conference, San Antonio, Texas, August 12-17, 2000.

Barrett, KL. Braithwaite, R., Krane, K., M. LaMarre, M. Creagh, T., Moore, W. "Women's Transition to Health and Healing: HIV Correctional Health Care/Education/Transition (CET) Team." The XIII International AIDS Conference, Durban, South Africa. July 9-14, 2000.

Bock, N., Reeves, M., and LaMarre, M. "Tuberculosis Case Detection in a State Prison System." *Public Health Reports.* July/August 1998. Vol. 113.

Uhl, Gary, Schwartz, I., Emshoff, J., Swift, R., LaMarre, M. & Lavinghouze, R., (1996). "Medical Chart Audit: A Tool to Assess Critical Care," Provided to Inmates with HIV/AIDS. Poster presented at the meeting of the American Evaluation Association, Atlanta, GA.

Nursing Protocols. Georgia Department of Corrections. October 1996. Co-author.

Hipkens, J., LaMarre M., Paris, J., Shansky, R. "How To: a Manual of Essential Elements for a CQI-driven Correctional Health Care Program." Georgia Department of Corrections. March 1996. Co-author.

Health Education and HIV Risk Reduction Program for Inmates at Correctional Institutions. Co-author. Revised January 1992.

LaMarre, M. "AIDS Inmates: A Dilemma for Management." *Corrections Today,* June 1988 50 (3) pp. 98, 100, 103, 127.

Presentations:

"Out of Sight: Out of Mind: Introduction to Correctional Health". Nell Hodgson Woodruff School of Nursing. Graduate Nursing Program. Atlanta, Georgia. July 18, 2012.

"Out of Sight: Out of Mind: Introduction to Correctional Health". Nell Hodgson Woodruff School of Nursing. Graduate Nursing Program. Atlanta, Georgia. July 21, 2010.

"Out of Sight: Out of Mind: Introduction to Correctional Health". Nell Hodgson Woodruff School of Nursing. Graduate Nursing Program. Atlanta, Georgia. July 1, 2009.

"Out of Sight: Out of Mind: Introduction to Correctional Health". Nell Hodgson Woodruff School of Nursing. Graduate Nursing Program. Atlanta, Georgia. July 16, 2008.

"Out of Sight: Out of Mind: Introduction to Correctional Health". Nell Hodgson Woodruff School of Nursing. Graduate Nursing Program. Atlanta, Georgia. August 3, 2006.

"Health Care Provider Role in the Prevention and Response to Prison Rape". American University. Washington DC. July 11, 2006.

"The Role of Health Care Providers in Prevention and Treatment of Prison Rape." Association of State Correctional Administrators Directors Training Program. Charleston, South Carolina. November 20, 2004.

"The Public Health Implications of Prison Rape: National Videoconference regarding the Prison Elimination Rape (PREA) Act." National Institute of Corrections. July 21, 2004.

"Incarcerated Women and Infectious Diseases. International Conference on Women and Infectious Diseases: From Science to Action." Centers for Disease Control and Prevention. February 28, 2004.

"Update on the Prevention and Management of Hepatitis A, B and C: New Recommendations from the Centers for Disease Control and Prevention (CDC)". American Correctional Association Conference. Nashville, TN. August 9-11, 2003.

"Prevention and Control of MRSA Infections in Correctional Facilities." Infection Control Conference. Georgia Department of Corrections. Forsyth GA. May 13, 2003.

"Improving the Health of Incarcerated Women Transitioning into the Community." Georgia Department of Human Resources, Division of Public Health. Forsyth, Georgia. May 12, 2003.

"Improving the Health of Incarcerated Women through Collaboration with Public Health." Centers for Disease Control and Prevention. Advancing the Health of Women: Prevention, Practice and Policy Conference. Atlanta, Georgia. October 7, 2002.

"Vulnerable Populations: Prisons and Aftercare." Georgia Chapter of Nurses in AIDS Care Conference, Atlanta, GA. October 12, 2001.

"Improving Collaboration between Corrections and Public Health." National Hepatitis Coordinators Conference. Centers for Disease Control and Prevention, Richmond, Virginia. July 29-August 2, 2001.

"Improving the Collaboration between Corrections and Public Health." Georgia Department of Human Resources (DHR) TB Nurses Coordinator Meeting. Stone Mountain, GA. July 19, 2001.

"The Legal Basis for Health Care in Correctional Settings." CDC Consultants Meeting: Recommendations for Prevention and Control of Viral Hepatitis among Incarcerated Persons. Mach 5-7, 2001.

An Introduction to Correctional Health Care. "Why the Public Health Must Go To Jail" Series. Centers for Disease Control, Atlanta, GA. January 12, 2000.

"An Introduction to Correctional Health Care." National Hepatitis Coordinators Conference. Centers for Disease Control. Tucson, AZ. May 24-27, 1999.

"Are People Behind Bars Part of the Community?" Panel Presentation. Fourth Annual Georgia Nurses Tuberculosis Conference. December 1-2, 1998.

"Profiling Special Needs Patients in the Correctional Setting: A Case Study of Process." Panel Presentation. 22nd National Conference on Correctional Health Care. Long Beach, California November 2-4, 1998.

"Clinical Update on Medical Management of HIV Disease-Initial Patient Workup and Treatment Plan." SPNS/HIV Training Series, Forsyth, GA., November 22, 1996.

"TB Control in Institutional Settings: Prisons, Hospitals and Long-Term Care Facilities." First Georgia Nurses' Tuberculosis Conference, Atlanta, GA. December 5, 1995.

"Chronic Care Clinics in Correctional Settings." GDC Health Services Clinical and Administrative Conference, Dillard, GA. November 30, 1995.

"Perspectives on Health Assessment and Classification Criteria." Co-presenter. 19th National Conference on Correctional Health Care, Washington D.C. November 14, 1995.

"Correctional Health Care: Improving Systems of Delivery." American Public Health Association, San Diego, CA. October 30, 1995.

"Primary Oral Management of the Patient with HIV Disease." Satellite Teleconference Series on HIV Care in Correctional Settings. National AIDS Education and Training Centers Program, Columbus, OH. April 26, 1995.

"Caring for Populations in Alternative Settings--The Incarcerated Client." Georgia State University School of Nursing, Atlanta, GA. March 9, 1995.

"Risk Assessment for HIV Infection and HIV Antibody Testing and Counseling: Implications for Corrections." Pennsylvania AIDS Training Network, Edinboro, PA. August 29, 1994.

"The Urethral Connection: Male Genitourinary Assessment." Georgia Nurses Association, Atlanta, GA. June 4, 1994.

"Management of HIV Infection." North Carolina AIDS Training Network, Durham, N.C. May 5, 1994.

"Psychosocial Issues for the Inmate." Pennsylvania AIDS Education and Training Center. Cresson Correctional Institution, PA. October 8, 1993.

"Management of HIV Infection." Metro Correctional Institution, Atlanta, GA. August 12, 1993.

"Tuberculosis." Metro Correctional Institution, Atlanta, GA. August 10, 1993.

"Psychosocial Issues for the Inmate." Pennsylvania AIDS Education and Training Center. Mercer State Regional Correctional Facility, Mercer, PA. June 24, 1993.

"Tuberculosis/HIV Update. Meeting Standards: County Health Care Staff." Georgia Public Safety Training Center, Forsyth, GA. April 15, 1993.

"Correctional Institutions: Linking the HIV Positive Client with Community Resources." The 1993 Middle Georgia Conference on HIV/AIDS, Fort Valley, GA. March 31, 1993.

CONTINUING EDUCATION ACTIVITIES (2000-2016)

Nurse Practitioner Certification Exam Review & Advanced Practice Update. Family, Adult-Gerontology and Adult Program. Fitzgerald Health Education Associates. Tucson, AZ. January 8-10, 2016.

Improving the Management of HIV Disease: An Advanced CME Course in HIV Pathogenesis, Antiretrovirals, and Other Selected Issues in HIV Disease Management. International Antiviral Society-USA. Atlanta, GA. March 10, 2015.

An Intensive Workshop on Evolving Strategies in Viral Hepatitis Management. International Antiviral Society-USA. Atlanta, GA. March 9, 2015.

The 17th Annual Update and Review of Internal Medicine 2013. University of New Mexico School of Medicine. Santa Fe, New Mexico. October 20-25, 2013.

The 16th Annual Update and Review of Internal Medicine 2012. University of New Mexico School of Medicine. Santa Fe, New Mexico. October 21-26, 2012.

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Seizures and Epilepsy: Demystifying a Common Disorder. Atlanta, Georgia. Wesley Woods Hospital of Emory University. February 22, 2002.

Massachusetts General Hospital HIV Resistance Preceptorship. Boston, MA. June 15, 2001.

Management of HIV/AIDS in 2001: The Role of Nevirapine. Atlanta, GA. March 24, 2001.

Improving the Management of HIV Disease: An Advanced Course in HIV Pathogenesis, Antiretrovirals, and Other Selected Issues in HIV Disease Management. Atlanta, Georgia. February 14, 2001.

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Exhibit 2

East Mississippi Correctional Facility (EMCF) Report

Submitted
February 25, 2011

Corrected June 20, 2011

Submitted by
Madeleine L. LaMarre MN, FNP-BC

Contents

Qualifications

I, Madeleine LaMarre, MN, FNP-BC have been retained by Plaintiffs' counsel as a correctional and nurse practitioner expert to review health care services at the East Mississippi Correctional Facility. Compensation for my work is being billed at $175 per hour and ½ my hourly rate for travel time, and $250 per hour for deposition or court appearances. In the following paragraphs I have summarized my background and experience in correctional health care as a prelude to this report. (Complete resume available at http://home.comcast.net/~mlamarre/resume_mlamarre.doc.)

I have practiced nursing for 30 years. I am a registered nurse and certified family nurse practitioner. Since 2005, I have been self-employed as a correctional health care consultant primarily involved in monitoring prison and jail compliance with settlement agreements, and providing technical assistance to correctional agencies to improve the quality of health care services and clinical outcomes.

My experience in corrections began in 1982, when I worked as a nurse practitioner/ administrator at the Atlanta Transitional Center, which is a Georgia Department of Corrections (GDC) facility. In 1984, I joined the GDC Office of Health Services full-time as a Nurse Consultant. My responsibilities within the agency grew over time and in 1995, I became the Statewide Clinical Services Manager. My responsibilities included the development of administrative policies regarding health care delivery; clinical guidelines including the treatment of HIV infection, hepatitis C, and other communicable and chronic diseases; and providing training to GDC health care staff. I was also responsible for a clinical auditing process that surveyed health care at over 40 correctional institutions, providing consultation to clinicians and nurses to improve health care delivery and patient outcomes. I have authored or coauthored a number of publications, and was an associate editor for a textbook on correctional medicine, Clinical Practice in Correctional Medicine, 2nd edition by Michael Puisis published in 2006. I am a member of the American Nurses Association, American Academy of Nurse Practitioners, and the Academy of Correctional Health Professionals.

In 2002, I was appointed by Judge Thelton Henderson to be a medical expert in the Plata v. Schwarzenegger case. This was followed by appointments as a health care monitor for other cases and at the end of 2004, I left the Georgia Department of Corrections to pursue this work full time. I am familiar with standards of nursing practice and correctional health care.

Document Review

I reviewed the following documents for this report.

1. Agreement of the Parties to Seek Order of Dismissal Without Prejudice, Presley v. Epps, No. 4:05-cv-00148.
2. GEO Corporate Policies and Procedures.
3. EMCF site specific policies on medication administration and crushing medications.
4. GEO Continuous Quality Improvement (CQI) studies January-September 2010
5. Report on Mental Health Issues at MSP Unit 32 by Terry Kupers MD, January 2010.
6. Memorandum from Gabe Eber and Carl Takei to Presley v. Epps Litigation team dated December 16, 2010 regarding Recent Visit to East Mississippi Correctional Facility
7. Memorandum from Gabe Eber to Presley v. Epps Litigation team dated November 30, 2009 regarding Mental Health Care-Unit 32-October 2009.
8. Chronic disease rosters

Overview

On January 25-27, 2011 I visited the East Mississippi Correctional Facility (EMCF) in Meridian, Mississippi. The purpose of the visit was to monitor compliance with the medical and mental health terms of the order of dismissal entered in *Presley v. Epps* (See Attachment 1).

I was accompanied by Terry Kupers, MD, psychiatrist and mental health expert and Margaret Winters, Gabriel Eber, and Carl Takei of the ACLU.

I performed the following activities in preparation for and during the site visit:

- Reviewed the medical and mental health requirements found in the order of dismissal
- Toured inmate housing units, main and satellite medical clinics
- Interviewed health care and custody staff
- Observed medication administration by nursing personnel
- Reviewed health records and other medically related documents
- Spoke with inmates

I would like to thank Warden Kenneth Reagans and GEO staff for their assistance in conducting this review.

EMCF is a privately owned facility operated by the GEO Corporation and which has an authorized capacity of 1360 inmates, expandable to 1500 inmates. The facility has a specialized mission of providing psychiatric services and individualized and group counseling.

Findings

Access to Care

The order of dismissal requires that the Mississippi Department of Corrections provides access to care that is timely and adequate to meet prisoners serious medical needs, and to ensure that services meet generally accepted community standards. It also requires that sick call services include adequate patient assessments, physical examinations, and treatment plans; and that referrals to mid-level or advanced level providers be made timely as clinically indicated.

To review this provision, I toured housing units and medical clinics, reviewed medical records, interviewed custody and health care staff, and spoke with inmates. Following my review, I found that at each step of the process, access to care services was not timely or adequate. Based upon the findings of this review, I conclude that this standard was not met.

The primary means for EMCF inmates to access health services is to submit a health services request (HSR) form to health care staff. During our tour of housing units 1, 3 and 5, HSR forms were not available to be distributed to inmates. In housing unit 5, inmates in long term segregation specifically complained to us of not having access to HSRs. Although correctional staff advised us that HSRs were available in the correctional officer control room, staff could not locate the forms in the control room.

Moreover, inmates have no opportunity to confidentially and securely submit their HSRs to health care staff. In housing unit corridors, lockable metal boxes were installed for inmates to deposit health service requests, mail, and grievances in the designated boxes. In several housing units the box for inmates to submit health care requests had no lock, thus anyone could access the box. Discussions with correctional staff revealed that instead of using the boxes, inmates typically give their written requests directly to custody staff, which does not provide confidential and direct access to health care staff.

Once health care request forms have been received by health care staff, nurses do not triage the forms and assess inmates in a timely manner. In a review of 33 health care requests in ten health records, we found that the average length of time for a nurse to see a patient once the HSR was received was 7.5 days. In 10 (30%) of 33 HSRs reviewed a nurse did not see the patient at all. This resulted in inmates submitting multiple requests to try to obtain access to medical or dental services.

Licensed practical nurses (LPNs) are assigned to triage HSRs and conduct patient assessments. Conducting patient assessments requires extensive knowledge of biological, physical, behavioral, psychological and sociological sciences for which LPNs are not prepared; have demonstrated competence; or are properly supervised.

It is therefore not surprising that we found the quality of the LPN assessments to be universally inadequate, even when performed according to a standardized procedure. For example, a 46 year old inmate submitted a request complaining of weight loss, constipation and needing a change in his diet. The LPN evaluated the patient using the constipation protocol. The LPN failed to take

an adequate history or address the patient's primary complaint which included a 30 lbs. weight loss in a 3 month period. The LPN failed to recognize that the patient may have a serious medical condition and instead treated the patient for simple constipation.

In addition, nurses did not refer patients when clinically indicated, and when they did make referrals to the physician, the appointments did not consistently take place in a timely manner, if at all. In several cases, nurses obstructed access to care by refusing to schedule appointments with the physician if he had recently seen the patient, even if complaint that was worsening, or was of a different nature. Record review also showed that inmates do not have timely access to dental care.

Once the physician saw the patient, we found that the quality of clinical evaluations was highly variable, and that in records we reviewed, the physician did not appropriately evaluate, treat, and monitor patients with potentially serious medical conditions.

An egregious example is a 46 year-old patient who presented with 35 lbs weight loss, abdominal pain and constipation for which the physician performed no meaningful history or physical examination other than to describe the patient as being emaciated. His only plan was to increase the calories in his diet. He did not consider the possibility that the patient may have a serious medical condition such as colon cancer (See Record Reviews Patient #2).

In another case, a 45 year-old patient presented to the physician with a 4 year history of heartburn and a 22 lbs. weight loss that the physician also performed no medical work-up of any kind. Further review of his record revealed that in May 2010 a thyroid screening test showed that the patient likely has hyperthyroidism. Neither the doctor nor the psychiatrist who ordered the test noticed or addressed this abnormality. The patient likely has had undiagnosed and untreated hyperthyroidism for at least 7 months (See Record Reviews Patient #4).

In another example, a 33 year year-old patient housed in long term segregation was brought to the clinic in August 2010 with head injuries following reported dizziness and fainting. He was sent out to the hospital and diagnosed with a skull fracture. Upon his return to the facility, the physician did not appropriately evaluate the patient's symptoms that led to his injuries; including questioning whether the patient's history matched the severity of the trauma. The physician doubted the diagnosis of skull fracture even though the diagnosis was documented in the hospital discharge papers; and he did not monitor the patient after his release from the infirmary. When the patient returned 3 weeks later with neurological symptoms (e.g., headaches, numbness, etc) that may have indicated complications related to his skull fracture (e.g. slow intracranial bleeding), the physician did not acknowledge his recent history of skull fracture in his evaluation of the patient. Following another incident in October 2010 which the patient was sent to the hospital, the physician did not see the patient for follow-up (See Record Reviews Patient #6).

In another case, a 45 year-old patient with a history of GERD and hepatitis C complained of a history of weight loss, ulcers and rectal bleeding. The physician confirmed that the patient had rectal bleeding but ordered no medical work-up. Over the next 3 months the patient continued to complain of vomiting and/or rectal bleeding and was not medically evaluated. (See Record Reviews Patient #5)

The medical care in each of these cases is below the standard of care. The physician is a retired neurosurgeon who is not trained and credentialed in primary care, thus it is not surprising that he does not provide patients adequate primary care. However, even in the case of the patient who suffered neurological trauma, which is within the physicians' area of expertise as a neurosurgeon, the physician did not adequately evaluate, treat and monitor the patient. In each of these cases, the physician's care was indifferent to the patient's potentially serious medical conditions.

I discussed these cases and concerns with Cassandra Newkirk MD, GEO Chief Medical Officer. Dr. Newkirk acknowledged that their internal peer review had shown that the physician's care was below the standard of care; and for the past several months had sought to replace him. However, because the physician's practice is dangerous to patients, he should be immediately removed from the facility and replaced with a physician who is trained and credentialed as a primary care physician (i.e., family practice, internal medicine).

Of particular concern is that inmates in segregation do not have access to health care request forms and health care staff does not consistently perform segregation rounds. It also a concern that when we toured the long term segregation housing unit, there were no correctional officers on 2 of the 4 housing pods for at least 20-30 minutes. Inmates we interviewed reported that there were periods of several hours in which no correctional officers were on the unit. If an inmate experienced a medical emergency, he would be unable to alert staff to the need for medical assistance.

An incidental, but significant finding was that in 6 of 10 records reviewed, inmates experienced significant weight loss, ranging from 13-30 lbs. The average weight loss among this group of inmates was 21 lbs. In a seventh record, the inmate was 6' feet tall and weighed 148 lbs. Although in some patients weight loss may be due to undiagnosed and untreated medical conditions, inmates also reported that they were not provided enough food and it was often served cold. If food is a scarce commodity, it also raises the questions of whether inmates prey on vulnerable inmates to give up their food.

Health Records

The order of dismissal requires that all health care will be properly documented in the medical record in accordance with community standards. To evaluate this area, I reviewed the availability and organization of health records, and timeliness of filing health record documents.

We found that in some cases MDOC did not transfer all volumes of the inmate's health record to EMCF and that health care staff did not have access to relevant medical information. We also found that health records were disorganized with documents out of chronological order. There is a backlog of document filing; lab and hospital reports are not tracked, reviewed and filed in a timely manner. Staff does not document all clinically relevant information in the record. Based upon the findings of this review, I find that this standard is not met.

Through record review and staff interviews, it was apparent that when inmates were transferred from MDOC to EMCF, not all volumes of the health record were forwarded with the inmate. This results in EMCF staff not having access to relevant clinical information necessary to provide adequate health care. For example, one patient was known to staff to have a history of seizure disorder, however, only the 5th volume of his health record was transferred to from MDOC to EMCF. This volume contained no information about the patient's history of seizure disorder, and the patient had not been evaluated for his history of seizure disorder since his arrival (see Record Reviews Patient #6).

The records are disorganized. Health documents are filed in more than one location in the record. There is no designated dental section and we found that dental records were not kept in a single location in chronological order. Diabetic flow sheets are scattered throughout the records.

Medication administration records (MARs) are not filed in the record in a timely manner. For MARs, the back log of filing goes back to September 2010. This does not enable clinicians to know whether patients are compliant with their medications, and to address issues of medication noncompliance.

We found that diagnostic and hospital reports are not obtained, clinically reviewed and filed in a timely manner. For example, the physician ordered an EKG on that was performed on 10/10/2010, but the doctor did not review it until 11/29/10.

Of significant concern is that staff does not contemporaneously document important clinical events in the record. For example, a 47 year-old patient with a history of hypertension experienced chest pain during medication administration and was sent out to the local hospital. There was no documentation in the record as to when the patient was actually sent out to the hospital or when he returned to the facility. In addition, there were no hospital reports in the record. The patient has not been seen for any reason since this event. We discussed this case with staff and learned that the patient was indeed admitted to Anderson hospital. Following our discussion, staff obtained the hospital admission report. In essence, this patient was lost to follow-up following his hospital admission and did not receive timely care.

Policies and Procedures

The order of dismissal requires that MDOC develops procedures to provide sufficient operational guidance to staff providing health care services including a written set of physician-approved nursing protocols. We evaluated this area by reviewing GEO corporate policies and procedures and selected nursing protocols found in the record. We requested that the complete set of nursing protocols be sent to us, but this has not yet occurred. Our findings revealed that this standard is not met.

I reviewed GEO's corporate health care policies and procedures. Although comprehensive, these policies and procedures were not specific to EMCF, and provided insufficient operational guidance to staff. Almost none of the corporate policies have been reviewed and updated on an annual basis; in fact most policies were last reviewed in 2008 or prior to this, some as long as 2004.

We were provided selected specific policies for review including medication administration and crushing of medications. The medication administration policy did not accurately reflect the actual times of medication administration. The policy related to crushing of medications is in conflict with the corporate policy states that medications will only be crushed in certain patient specific circumstances; whereas the EMCF policy requires crushing of all medications for every patient at EMCF.

Chronic Disease Management

The order of dismissal requires that patients with chronic conditions are seen in chronic care clinics in accordance with their level of disease control and in accordance with nationally accepted guidelines. This area was evaluated by reviewing health records with respect to timeliness and appropriateness of chronic disease care.

We found that following their arrival, that patients are scheduled to see the physician in a timely manner. However, the quality of the physician's evaluations is variable and in many cases inadequate. The physician also does not evaluate patients for clinical findings that may be unrelated to the chronic disease, but are clinically significant such as weight loss and GI bleeding. There are significant problems with lab tests being performed as ordered and the physician has not taken any effective action to resolve the issue. As a result, the physician does not have important information necessary to manage the patient's chronic disease. Based upon the findings of this review, this standard is not met.

On a positive note, for newly arriving inmates nurses complete a receiving screening/transfer form to identify their health needs and arrange for continuity of care. With respect to patients with chronic diseases, we found that these patients were enrolled in the chronic disease program and seen by the physician in a timely manner. Generally, the first chronic disease appointments were scheduled 5-10 days following the patient's arrival.

However, review of records showed that the physician does not take appropriate baseline and interval histories related to the patients' chronic disease. For example, for asthma patients the physician did not ask baseline history questions such as date of onset, precipitating factors, frequency of symptoms, or history of hospitalization and intubation. For patients with hypertension the physician did not consistently inquire about cardiovascular symptoms at each visit. In one case, the physician did not ask these questions and the following month the patient experienced chest pain and was sent emergently to the hospital (See Record Reviews Patient #7). One patient reported having a history of diabetes, but the physician did not explore this history (See Record Reviews Patient #1).

At each visit, the physician did not address all chronic diseases. For example, one patient had diabetes, GERD and hepatitis C, but the physician never evaluated the patient's hepatitis C. This patient was presenting through sick call with complaints of ulcers and rectal bleeding, but the physician did not attempt to evaluate his symptoms in light of his history of having hepatitis C (See Record Reviews Patient #5).

The physician did not note, evaluate and address other symptoms of potentially serious medical conditions, especially weight loss. In 6 of 10 records reviewed, patient weight loss ranged from 13 to 30 lbs (average weight loss was 21 lbs.), and the physician never performed any medical evaluation. In one case a patient also had GI symptoms that raised a concern about malignancy, and in another case the patient thyroid tests suggested hyperthyroidism (See Record Reviews Patient #2 and #4).

The physician did not schedule patients for follow-up in accordance with their disease control. One patient with poorly controlled hypertension was scheduled for follow-up in 3 months when this should have occurred sooner (See Record Reviews Patient #5).

A significant issue is that the physician ordered appropriate lab tests but these tests were rarely completed as ordered, and the physician never took any effective action to obtain the tests other than to reorder them, and in many cases with the same outcome. As a result, the physician lacked key information to appropriately evaluate and treat patients. For example, for hypertension patients, the physician ordered lipid panels, but these tests were often not completed and the physician was unable to evaluate and treat patients with high cholesterol.

As the physician is ultimately responsible for the patients care, he should have taken effective action to ensure that the tests were completed. This would have included documenting that he addressed the problem with the health care administrator and planned to have the patient return again following successful completion of the tests; however in none of the records I reviewed did this take place.

The physician did not address the role of medication adherence in whether the patient's disease was well controlled or not. In the case of a patient whose hypertension was poorly controlled, medication records showed that he frequently did not take his medication. However the physician did not inquire about or address the reasons for the patient's nonadherence, instead simply adding another medication to his regimen. This strategy is not likely to achieve better disease control (See Record Reviews Patient #9).

The physician did not provide all aspects of care in accordance with national guidelines. One diabetic patient had not had an eye examination since 2008 (See Record Reviews Patient #5).

Finally, an incidental finding was that the physician delegated reordering of chronic disease medications to nurses at each chronic disease visit. When we inquired about this, we were told that the physician refuses to write his own orders. This increases the risk of transcription errors resulting in medication errors, and should not be done.

Health Care Staffing

The order of dismissal requires MDOC to maintain sufficient numbers of qualified health care professionals to meet prisoners' medical needs and sufficient security to ensure timely patient escorts to clinics. MDOC will ensure that all persons providing medical treatment possess licensure and/or certification that permit them to practice within the state of Mississippi and that such persons practice only within the scope of their training and licensure.

I evaluated this provision by reviewing staffing patterns, staffing assignments, timeliness of access to care, and physician training and credentialing. I found that the current staffing pattern is insufficient for a facility of its size and specialized medical and custody missions; and find that the physician is not practicing within his scope of training and certification. Based upon our review, this standard is not met.

Ms. Teresa Shepherd RN, HSA is the health care administrator who has been at the facility for approximately one month. She previously worked at EMCF and has experience as a correctional health care administrator. We were very impressed with Ms. Sheperd's conscientiousness and interest in providing care to the patient population.

The facility does not have a budgeted Director of Nurses position.

With respect to clinical staffing, currently there is a 1.0 clinical FTE occupied by a retired neurosurgeon. He is scheduled to work 0730 to 1600, Monday through Friday. He is also on-call 24 hours per day, 7 days per week for 365 days per year. Staff reported that when the physician is on vacation, the corporate Medical Director is on-call for the facility. With respect to patient volume, it was reported that the physician sees approximately 25-30 patients per day depending on the demand.

With respect to nurse staffing, currently there are a total of 7.0 FTE registered nurses and 17 FTE licensed practical nurses.

The nurses work 12 hours shifts, 0700 to 1900. There are 4 nurses assigned to each shift, 7 days a week. Each shift typically has 1 RN and 3 LPNs. In addition, there is a chronic disease and psychiatric nurse; and an LPN assigned to the pharmacy.

Prior to October 2009 the facility was staffed with a full time physician for 800-900 inmates. Subsequently housing units 5 and 6 were opened increasing the population by 400-500 high custody inmates, many of whom were mentally ill. However, clinical staffing was not increased, and record review shows serious problems with access to the physician.

In addition, there are insufficient numbers of budgeted registered nurse positions. As a result, LPNs are assigned to perform nursing sick call, for which they are not properly educated, trained, competent nor supervised.

Pharmacy Services and Medication Administration

The order of dismissal requires the MDOC to provide inmates their ordered medications in a timely manner, without interruption; and to administer and document medications in accordance with accepted nursing standards.

I evaluated this provision by observing a nurse administer medications in the housing unit; reviewing health care records, interviewing staff, and reviewing applicable policies. We found that there are serious issues with medication services at EMCF. This includes incomplete physician orders; lack of medication continuity upon arrival, interruption of medications; medication administration practices that do not meet generally accepted nursing practice; and frequent medication errors.

Pharmacy Services

At EMCF, pharmacy services are provided by CorrectRx. According to staff, if medication orders are faxed to the pharmacy before 3 pm, medications usually arrives the following day. The facility also has a contract with a local pharmacy and a limited stock supply of medications which includes antibiotics and psychotropic medications.

The only controlled substances kept at the facility are Tylenol #3 and Phenobarbital. This is a very restricted formulary of narcotic medications. Record review shows that the physician underutilizes narcotics to manage acute, severe pain.

Medication Administration Process

Medication administration takes place twice daily, at 0400 and 1600. In general population (Housing units 1-4 and half of unit 6) inmates come up to a window to receive their medications. In segregation (housing unit 5 and 6D) nurses go cell to cell. A correctional officer is assigned to each nurse. The officer is supposed to provide general security and conduct oral cavity checks.

Typically, there are 3 nurses assigned to administer medication to the six housing units. Each nurse is assigned 2 housing units to administer medications. Generally medication administration takes 1.5 to 2.0 hours per housing unit if there are no interruptions. However, often medication administration is interrupted for inmate counts, feeding and other unplanned activities. Thus, it typically takes 3-4 hours for each nurse to administer medications. This is not in compliance with accepted nursing practice to administer medications within a one hour window before or after a set time. Using the current medication administration times, this would mean that nurses would administer medications between 0300 and 0500 for the designated 0400 administration; and between 1500 and 1700 for the 1600 medication administration. This is not occurring. Moreover, it is not reasonable to begin medication administration before 0400 because it negatively impacts inmates sleeping patterns and would likely increase medication noncompliance.

At EMCF nurses administer *all* medications. This includes psychotropics, narcotics, antibiotics, chronic disease medications, as well as over-the-counter medications. The facility does not

permit inmates to maintain possession of any medications, except inhalers and creams. This is highly unusual, as in many correctional facilities around the country inmates are permitted to maintain medications in their possession except psychotropics, narcotics, and selected medications that should be closely monitored (e.g., warfarin). Staff explained that this has been a long standing policy from the time the facility was first established as a mental health facility. The policy increases the volume of nurse administered medications and the length of time to administer medications.

In addition, there is a policy that medications are to be crushed and floated in water prior to administration to the patient, except for sustained-release and a limited number of exceptions. Even antihypertensives, diabetic, and over the counter medications are to be crushed.

This practice is problematic for several reasons:

- When medications are crushed, invariably the patient does not receive the full dose of medication as some of the medication remains as residue in the container that the medication is crushed in as well as the patient's medication cup.

- Crushing and mixing of several medications together is unpalatable to most patients and negatively impacts medication adherence. Nursing staff reported that inmates refuse their medications on a regular basis because of the policy of crushing medications.

- Inmates are not able to identify what medications they are receiving or not receiving and cannot participate in identification of medication errors (e.g. wrong medication, missing medications, etc). One mental health inmate stated that he was not aware his mental health medications had been discontinued and that he was only receiving medications for his medical condition because he was unable to identify the missing medication in a crushed mixture.

For these reasons, the wholesale crushing of medications is unreasonable. In most correctional facilities with which I am familiar, medications, including psychotropic medications are only crushed based upon a patient specific order to do so and for a sound reason, such as inability to swallow medications, known hoarding, etc. This practice should be discontinued.

I observed a nurse administer medications on housing unit 1 and found it to be very problematic.

- The correctional officer did not control inmate movement to and from the medication window to ensure that medication administration occurred in a smooth and orderly manner. In addition, more than one inmate was often standing at the window which reduces privacy and increases the risk of error.
- The nurse did not positively identify inmates using an inmate identification badge. Staff reported that inmates have badges but rarely carry them on their person.
- The nurse maintained cups full of *unlabeled medications* in the medication cart including Prozac, Aleve, Tylenol, Ducolax, etc. *This is an illegal and dangerous practice.*

- The nurse crushed each medication and poured it into a medication cup per institutional policy, which left significant amounts of residue in the envelope that it was crushed in as well as the medication cup.
- Neither the nurse nor the officer watched each inmate take his medication at the window. One inmate walked away from the window with the medication in the cup.

Health Record Documentation

I reviewed medication administration records (MARs) to assess nursing documentation. The pharmacy company, CorrectRx automatically prints medication administration records. However, electronically printed MARs do not capture any new prescriptions written after the 20th of each month. This results in nurses having to manually transcribe any new medication orders after the 20th of each month. This is a time consuming process that increases the likelihood of medication transcription errors. It would be more reasonable to have the cutoff period closer to the end of the month (e.g. 25th of each month). Some MARs show an incorrect medication start date (See Record Reviews Patient #1).

Review of the health record revealed a number of medication related documentation issues, including medication errors. This includes the following:

- In 2 of 10 records the physician did not sign medication orders that were written upon the inmate's arrival at the facility. Thus, the medication order was not legal but the pharmacy filled the order regardless. In other records, medications were not reordered by the physician but continued by the pharmacy.

- The physician does not write his own medication orders when seeing chronic disease patients; instead, he delegates this to a nurse. This increases the likelihood of medication transcription errors and should not be done. The physician should write his own orders.

- Review of MARs showed that it took 2-5 days for the inmate to receive his medication following his arrival at the facility, including inmates taking insulin.

- MARs showed that there were frequent interruptions in medications being available to inmates. Interviews with staff revealed that nurses do not consistently order refills from the pharmacy in time to prevent disruptions in medication continuity.

- Medication orders were sometimes changed without clinical documentation. For example, one newly arrived diabetics order for insulin was changed from Humulin to Lantus without a clinical evaluation or progress note.

- MARs show patterns of inmate no shows and refusals of medication that are not addressed by nursing or the physician.

- Finally, record review showed that the psychiatrist routinely discontinues or changes psychotropic medication for newly arriving patients. The psychiatrist's rationale for

discontinuing the medication focused primarily on his belief that the inmate was malingering, not mentally ill, was refusing his medications or was noncompliant. While certainly there are patients who may meet these criteria, the fact that almost every patient met one of these criteria raises serious questions about his therapeutic approach. This is addressed further in Dr. Kupers' report.

In summary, the medication delivery system at EMCF does not ensure that patients receive their medications in a timely manner, without interruption, and according to generally accepted nursing practices.

Quality Improvement and Clinical Performance Reviews

The order of dismissal requires MDOC to conduct quality improvement activities and adequate clinical performance reviews and to supervise all clinical staff. We evaluated this by reviewing CQI documentation for January to September 2010 and interviewing the current health care administrator. We found that although CQI studies were consistently performed from January to September 2010, no studies have been performed for the past 4 months. Although we did not review clinical performance documents of the physician that were performed by the GEO regional medical director, we were informed that these reviews have been conducted, identifying serious physician performance issues. Based upon this review, the standard is not met.

Staff reported that the previous health care administrator was personally responsible for conducting all CQI studies. From January to September 2010 areas that were studied included access to care, chronic care, physician records, laboratory services, pre-segregation evaluations, radiology, pharmacy and nursing documentation.

We reviewed the results of studies conducted from January-September 2010. Almost all studies showed extremely high compliance. In some cases there were discordant findings with our results. For example, the May 2010 quality improvement study on laboratory tests showed that for 10 charts, 100% of labs were completed within 7 days. Our review of records which approximated the same period of review showed that in almost all cases labs were not drawn as ordered. For access to care studies, in a sample of 8 records, the results showed a compliance level of 92-96%. A June 2010 review of physician medical records the physician scored 100%. Given the findings of our review, these findings of high CQI compliance raises questions about the criteria used to achieve compliance.

No studies have been performed since September 2010.

Dr. Newkirk reported that GEO has performed clinical performance for the physician, and that they have determined that there are significant clinical issues with his care. They plan to replace him but have not yet found a replacement.

We are unaware of whether any peer review has been performed for the psychiatrist, whose care was found to be extremely problematic (See Dr. Kupers report).

Patient Record Review

Patient #1

This 33 year-old arrived at EMCF on 3/3/10. His medical history included hypertension, depression, delusions and personality disorder. Upon arrival his medications were Celexa and Clonidine.

Transfer Screening

On 3/3/10 a nurse performed transfer screening for the patient that including renewing his medications. The patient did not receive his Clonidine for 5 days after his arrival and his Celexa 4 days after his arrival.

Mental Health

On 3/4/10 mental health staff performed an assessment and noted that at MSP he was treated for delusions, depression, anxiety and anger management. On 3/15/10 the psychiatrist saw the patient and documented that he provided no credible information regarding his symptoms. He stopped the patient's Celexa.

Chronic Disease Management

On 3/16/10 the physician saw him for chronic disease management. He obtained the patient's family and social history, but did not obtain any cardiac history (e.g. chest pain, shortness of breath, etc). The patient stated that he was diabetic but the physician did not explore this further. The physician performed an appropriate physical examination, however he did not assess the patient's hypertension disease control. The physician plan included changing his blood pressure medications, ordering labs and diagnostic tests, and a plan to follow-up the patient in 3 months.

The patient's medications were documented as being administered in a timely manner. The chest x-ray was performed on 4/2/10 but the report was not reviewed until 4/19/10. An EKG was obtained on 4/17/10 and reviewed 4/19/10. Lab tests (lipid panel and biochemical profile) were not done. On 6/15/10 the physician saw the patient for follow-up but did not address that labs were not performed as ordered.

Medication Administration Records

His April 2010 medication administration record (MAR) showed that he was grossly noncompliant (many documented no shows) for his blood pressure medication. The nurse who documented the no shows (NS) did not document her initials. His May 2010 MAR showed 5 days in which his medication was not available. Discussions with staff indicated that there has been a problem with nurses ordering medication refills from CorrectRx. This has resulted in disruptions in medication continuity.

His July MAR showed that the pharmacy had an incorrect start date for the medication (6/23/10 versus actual date of 61/5/10). MARs through September 2010 are in the record. Staff reported that they are behind in filing medical records.

September 2010 MAR shows that some nurses use a single initial (S) instead of two initials.

Sick call (Housed in 5A)

1. On 6/6 the patient submitted a HSR complaining of abdominal pain and gas from being served cold food trays. He was requesting refill of medication for gas. It was received the following day. On 6/14/10 an LPN saw the patient (7 days after the HSR was received). She measured vital signs but no temperature. The only subjective data collected was c/o headache, back pain, gas. No objective data, nursing assessment or plan was documented.

2. On 6/18/10 he submitted a HSR form complaining of "harsh breathing problems due to being forced to live in cruel conditions due to inmates setting fires, throwing body fluids, and officers using mace in large amounts". He also complained of migraine headaches. It was received 6/19/10. On 6/24/10 (5 days after the HSR was received) an LPN saw the patient. The only subjective information was that the patient was short of breath. The LPN measured vital signs and obtained an oxygen saturation level that was abnormally low (87%, normal >95%). The assessment was "no signs and symptoms noted". The nurses' plan was to routinely refer the patient to the physician for evaluation of oxygen saturation.

On 6/29 the physician saw the patient and noted that he said he has shortness of breath because he was sprayed with chemical agents. The patient's vital signs and oxygen saturation were normal and his lungs were clear without wheezing. The diagnosis was no pathology and his plan was to monitor the patient.

3. On 11/7/10 the patient submitted an HSR complaining of blood from his penis, neck pain and swelling, fever, cold symptoms and gas. It was received on 11/8/10. An LPN did not address the HSR until 11/16/10 (9 days) noting that another nurse saw the patient on 11/12 (however only a urine dipstick was performed at that time). The LPN referred the patient to a clinician however this referral did not take place.

4. On 1/20/2011 the patient submitted an HSR complaining of headaches, runny nose, and low back pain. He requested to see a nurse or doctor. An LPN collected the form and saw him the following day (0 days). The LPN completed the subjective and objective portions of the upper respiratory protocol, but did not document a nursing diagnosis. The nurse treated the patient for an upper respiratory infection. The nurse did not evaluate the patient's back pain.

In November 2010 he submitted a written complaint stating that the nurses refused to give him his medication because he disrespected him. The HSA said they had a right to refuse him medical care if they see you as dangerous. This is not appropriate.

Segregation Rounds

Medical staff is supposed to make daily rounds in segregation, stopping by each cell and asking inmates how they are doing. His September 2010 Segregation Daily Evaluation form was not completely filled out with respect to the date he was admitted and discharged, whether he was on a special diet and or taking medications. The first rounds were documented on 9/14 and 9/15/10, no rounds documented on 9/16 and 9/17 then rounds documented on 9/18/10 and 9/19/10. Staff signed the form.

Summary: This record showed numerous problems included delays in receipt of medications following arrival at the facility; delayed access to nursing sick call; inadequate nursing assessments by LPNs; delays or unsuccessful physician referrals; discontinuity of medications; pharmacy documentation errors; and lack of segregation rounds.

Patient #2

This 46 year-old arrived at EMCF on 8/19/09. His medical history included depression and bipolar disorder with self mutilation. He is currently taking lithium carbonate.

Transfer Screening

On 8/19/09 a nurse completed a transfer screening and noted that he was taking Remeron and Lithium. The intake orders were not signed, thus it was not a legal order. His intake weight was 152 lbs.

On 8/20/09 the psychologist saw the patient and noted that his mental health diagnoses were antisocial personality and bipolar disorder.

On 9/10/09 the psychiatrist saw the patient and stated that he was malingering to obtain a transfer to EMCF and he doubted diagnosis of bipolar disorder. He ordered labs and follow-up in 3 months. He continued the Lithium. He saw him periodically.

Sick Call and Medical Care

On 11/17/09 the physician saw the patient for complaints of weight loss. The patient had lost 35 lbs (152 lbs→117 lbs) in 3 months. The doctor did not obtain any subjective history at all. His diagnosis was that the patient had weight loss and was emaciated and he placed him on an increased calorie diet. He did not plan any follow-up.

5. On 2/2/10 the patient submitted a health service request (HSR) complaining of serious weight loss (30 lbs) and change in diet. On 2/3/09 the form was received. On 2/8/09 (5 days) an LPN saw the patient and noted that he complained of dry skin and constipation. He was 5' 5" and 121 lbs. No other objective data was collected. Her plan was to not treat the patient's dry skin. She did not refer the patient for evaluation of weight loss.

6. On 2/18/10 the patient submitted another HSR complaining of having a bad case of constipation and Miralax not working. The form was not date stamped regarding receipt. On 2/23/10 an LPN triaged the form and referred him directly to the doctor. On 2/23/10 the doctor saw the patient noting that he was constipated and wants snacks. His body mass index (BMI) was 13% his assessment was emaciated. His plan was hypercaloric diet and a stool softener.

7. On 3/20/10 the patient submitted an HSR complaining of abdominal pain and being bloated for more than a month. The form was collected on 3/21/10 and on 3/23 (2 days) and LPN saw the patient using a nursing protocol. The nurse treated him for constipation and did not refer the patient. Chronic Disease Management

On 3/25/10 his TSH was elevated (31, normal 0.45-4.5) indicating hypothyroidism. The psychiatrist reviewed the report the same day and referred the patient to the physician.

On 3/30/10 the physician saw the patient for evaluation. He did not take any history related to hypothyroidism. He noted that he was taking Lithium. He planned to obtain a thyroid panel and see the patient in 2 weeks. On 4/13/10 the physician saw the patient and started him on levothyroxine 0.50 mcg daily. There are no MARs from September-November 2010 in the record; his January and December MARs show good medication compliance.

On 4/13/10 the doctor saw the patient for follow-up of labs. His TSH was elevated (24.4). The physician did not address the patient's weight loss. His plan was to see the patient in 3 months. By August his TSH was approaching normal (approximately TSH=7).

8. On 4/19/10 the patient submitting an HSR requesting to see the physician for his thyroid problem that affected his metabolism and appetite. The LPN wrote to the patient that on 4/13/10 the doctor saw him should have discussed it with him at that time.

9. On 4/21/10 the patient complained of flu-like symptoms chills and fever. On 4/26/10 the nurse documented "No s/s of cold visual (sic) at cell door.

On 7/13/10 the physician saw him for chronic care. He did not obtain any interval history other than to note medication adherence. The patient's weight was 129 lbs.

On 10/29/10 the patient told the psychiatrist that "the only thing I want to talk about is that fainting, I feel weak".

10. On 11/3/10 he submitted another HSR complaining of weight loss and wanting to see the doctor about his diet. An LPN saw the patient the following day and weighed him (135 lbs) and indicated no treatment for the patient.

11. On 11/4/10 he submitted another HSR stating that he needed to see the doctor about his diet, and that he felt weak and sick. This HSR was received on 11/8/10 and an LPN saw him on 11/15/10 (7 days). His weight was 133 lbs.

12. On *illegible* date he submitted another request for the same problem that was received on 11/17/10. On 11/23/10 (6 days) an LPN saw the patient and said he had already been seen. He kept submitting repeated requests that the nurses did not adequately address.

13. On 12/6/10 he submitted another HSR. His weight was 123 lbs. The nurse did not refer the patient.

Summary: This record shows multiple problems; the most egregious is the physician's repeated failure to address the patients documented 30 lbs weight loss, constipation, and abdominal pain which are suspicious for GI malignancy. We discussed and referred this record with Dr. Cassandra Newkirk MD, GEO Chief Medical Officer for further follow-up. Other problems included persistent delays in access to care; inadequate LPN nursing assessments and failure to refer the patient back to the physician. At the transfer screening, a physician did not sign the order to continue his medications.

Patient #3

This 23 year-old arrived at EMCF on 4/9/10. His medical history included asthma, hypertension, seizure disorder and latent TB infection. His current medications are HCTZ, Dilantin, ASA and Albuterol MDI.

Transfer Screening

On 4/9/10 a nurse completed a receiving screening form. His medications were reordered upon arrival and initiated on 4/11/10.

Chronic Disease Management

On 4/13/10 the physician saw the patient for chronic disease management. His blood pressure was 130/77 mm/hg. He did not document the patient's level of disease control. He ordered labs, medications and requested follow-up in 6 months. The labs were not obtained.

On 10/12/10 the physician saw the patient again for chronic disease management. The patient was in good control which was documented by the physician. He requested CBC with differential, chemical profile, Dilantin level and urinalysis. The labs were not obtained.

14. On 1/23/11 the patient submitted an HSR complaining of penile problems. The form was collected the following day and on 1/25/11 (2 days) an LVN saw the patient. The patient's blood pressure was elevated (143/95 mm/hg) but the nurse did not note or address this finding. The assessment consisted only of "penis is irritated". No additional subjective or objective data was documented. The nurse gave the inmate triple antibiotic cream.

Summary: The patient's medications were continued upon arrival. Labs for chronic disease visits were not obtained as ordered. The LVNs assessment was inadequate and did not address the incidental finding of an elevated blood pressure.

Patient #4

This 42 year-old arrived at EMCF on 4/19/10. His medical history included bipolar disorder with psychosis; and 3 previous suicide attempts. Prior to his arrival at EMCF he was prescribed Risperdal, Tegretol and Wellbutrin.

Transfer Screening

On 4/29/10 the psychologist interviewed him and found him to be grandiose, narcissistic with difficulty focusing.

On 5/6/10 the psychiatrist saw the patient and his assessment was "rule out malingering and doubt a history of bipolar disorder". He stopped his medication due to patient refusal.

Undiagnosed illness

On 5/6/10 the psychiatrist orders labs tests including a TSH which is abnormally low (0.18) indicating that the patient is hyperthyroid. The psychiatrist reviewed the lab report but did not address his abnormal thyroid test result and it has not yet been noted or addressed. Review of his

record showed that as of December 2010 the patient has had 24 lbs. weight loss in 3 years, which is consistent with hyperthyroidism.

Sick call

15. On 5/21/10 the patient complained that a tooth needed to be filled or pulled. A nurse did not see the patient.

16. On 6/11/10 he submitted a second HSR repeating his complaint. A nurse did not see the patient.

17. On 7/27/10 he submitted a similar request. A nurse did not see the patient.

18. On 8/26/10 he submitted a fourth request.

19. On 9/28/10 he submitted another request. The dentist saw the patient on 10/3/10 and noted that he had cavities. His plan was RTC for fillings with no time frame. He had not been seen since.

Dental records are mixed in with other records under the first tab. There is no dental section of the record.

20. On 9/20/10 he submitted an HSR complaining of left sided rib and chest pain. The form was received the same day. On 9/23/10 an LPN (3 days) saw the patient. The history consisted of "bad pain in left side unrelieved by Tylenol". The nurse measured vital signs but did not examine the patient. The plan was to refer the patient to a physician. On 10/12/10 (19 days) the physician saw the patient.

21. On 10/18/10 he submitted an HSR complaining of acid reflux and stating he needed Prilosec. On 10/20/10 the HSA wrote that he did not have an order for the medication.

22. On 10/23/10 the patient submitted another request stating that he had severe reflux and needed to see the doctor. The form was collected the following day. On 11/16/10 (23 days) an LVN saw the patient and noted that he was having severe heartburn and his medication was not working. The nurse measured vital signs (except temperature) and weight (150 lbs), but did not examine the patient. The nurse referred the patient to the physician.

On 11/23/10 (7 days) the doctor saw the patient. He noted that the patient complained of heartburn for 4 years and weight loss but did not quantify the weight loss (22 lbs, 168→146 lbs). He asked no questions about fever, chills, night sweats, anorexia, nausea, vomiting, diarrhea, constipation, abdominal pain or blood in stools. An abdominal examination was normal. His BMI was 19%. His diagnosis was acid reflux and he prescribed Prilosec and a high calorie diet.

23. On 11/1/10 the patient submitted an HSR complaining of having a runny nose and cough. It was received on 11/4/10. On 12/1/10 (27 days) an RN saw the patient and completed a nursing assessment protocol. (Afebrile, BP=141/85 mm/hg, pulse=45 beats/minute, respirations=18 breaths/minute. His weight was 144 lbs. The nurse did not document an assessment, note the patients continued weight loss, extremely low pulse, elevated blood pressure.

Segregation

Segregation records showed that in September that segregation rounds were made on 9/14 and 9/15/10, no rounds were made on 9/16 and 17 and rounds made on 9/18 and 9/19/10. The form was not filled out as to when the patient was admitted and released from segregation.

Summary: The record shows numerous problems including physician failure to address abnormal thyroid function tests and weight loss indicative of hyperthyroidism; delays in access to care; inadequate nursing evaluations; delayed physician referrals. Lack of daily segregation rounds.

Patient #5

This 45 year-old arrived at EMCF on 4/27/10. His medical history included diabetes, hypertension, GERD, constipation and hepatitis C. Upon arrival his medications were Risperdal, Humulin R and Humulin N, aspirin, Mylanta, Ranitidine and Colace.

Transfer Screening

Upon arrival a nurse performed a transfer assessment. The patients' blood pressure was 144/99 mm/hg, pulse=109 beats/minute, respirations 20 breaths/minute, afebrile. His weight was 177 lbs. His medications were renewed upon arrival however the nurse did not write an order to continue the patient's aspirin and Mylanta; and inexplicably changed the insulin orders from Humulin to Lantus 40 units. His aspirin was not ordered but was continued anyway.

His Lantus and Risperdal were not started for 4 days until 5/1/10.

On 4/27/10 the psychologist saw the patient and noted his history of paranoid schizophrenia. On 5/19/10 he told a psychologist that he heard voices telling him to kill himself.

On 5/27/10 the saw the psychiatrist saw the patient. His diagnosis was rule out malingering and rule out psychosis. He discontinued the patients' Risperdal, ordered labs and planned to follow him in the infirmary.

On 1/17/11 the psychiatrist saw the patient who stated that he needed to be placed back on Remeron and Risperdal. He stated that he never knew he had been taken off of it. The psychiatrist wrote that there was no current indication for renewing his medication.

Chronic disease management

On 5/4/10 the doctor saw the patient for chronic disease management. He noted that the patient had diabetes for one year and was on insulin only. The patients BP= 144/104 mm/hg and his weight was 174 lbs. He did not assess the patient's disease control. He ordered a chemical profile, lipid, hemoglobin A1c, microalbumin, and urinalysis (none that were done), started the patient on HCTZ and Lisinopril, continued Lantus 40 units and put the patient on ASA 81 mg. However the transcribing nurse did not note the change in dosage from 325 to 81 mg and he has been continued on 325 mg. (medication error). The physician planned to see the patient in 3 months which was not appropriate given that his blood pressure was poorly controlled and he was starting the patient on a new medication.

On 8/12/10 he saw the patient for follow-up documenting that he had no chest pain or shortness of breath. He did not obtain a diabetes interval history. His blood pressure=130/82, pulse= 83 beats/minute and respirations 16 breaths/minute. The patient's weight was recorded as 257 lbs which is an increase of 75 lbs and most likely a documentation error but the doctor did not note or address this finding. He did not assess disease control for any disease. He did not address his hepatitis C infection or recent complaints of rectal bleeding. The physician documented that previously ordered labs were not done, however they were done and signed by the physician on 8/9/10. The patient's HbA1c was 5.9%. LFTs normal, LDL was 96. He did not review fingerstick blood sugars. He ordered more labs and continued the same medications. He requested follow up in 3 months. The doctor did not write his own medication orders, delegating this to the nurses. This increases the risk of medication transcription errors.

On 11/10/10 the doctor saw him for follow-up. The patient denied chest pain or SOB. The physician did not inquire about hypoglycemia. The patients blood pressure=130/90 mm/hg and his weight was 166 lbs. The doctor noted that no labs were obtained. He did not assess the patient's disease control although his blood pressure was above goal (<130/80 mm/hg). He continued medications, ordered labs and requested follow-up in 3 months. The doctor did not write his own medication orders. He wrote an order to draw labs but this was not done. The patient has not had a diabetic eye exam since 2008.

Diabetic flow sheets are all over the chart.

Sick call

24. On 5/17/10 he submitted an HSR complaining of having problems with his ulcers bleeding again from not being able to use the bathroom. The HSR was received on 5/19. Nurse saw the patient on 5/21/10 (2 days). The patient's weight was 172 lbs, afebrile, BP 98/70, pulse 88 and respirations 18. The nurse c/o bleeding ulcers, "dark red there when wipe clots on tissue". The nurse referred the patient to the physician.

On 5/25/10 (4 days) the physician saw the patient who complained of weight loss and bleeding ulcers. He documented: "I/M said he had ulcers before 2-3 months while at Parchman when he move his bowels red blood in stools." His weight was 165 lbs (↓12 lbs, BMI 24%). His vital signs were otherwise normal. He examined his abdomen which was soft with no masses and no hemorrhoids noted. He documented that the patient's fecal occult blood test was positive. His assessment was "? Ulcer" and his plan was to order Prilosec and return in week for another rectal examination.

On 6/2/10 the physician saw him again for follow-up. He documented that the patient had no abdominal pain or tarry stools and a rectal examination was negative for occult blood. His diagnosis was questionable PUD (peptic ulcer disease) and to continue Prilosec.

25. On 6/26/10 he submitted an HSR complaining of continued problems with bleeding ulcers from the rectum when using the bathroom. The form was received on 7/27/10 the nurse documented no treatment indicated already on Prilosec. The nurse did not refer the patient to the doctor.

26. On 8/24/10 the patient submitted an HSR complaining of vomiting and still bleeding when he used the bathroom. The form was received the following day. On 8/27/10 the nurse documented that the physician saw the patient on 8/12/10 no further treatment indicated, even though the physician did not address the patient's symptoms. His weight was 164 lbs. BP=142/80 mm/hg. Nurse did not address his elevated blood pressure.

27. On 8/30/10 he submitted an HSR complaining of severe testicular pain. A staff member responded wrote that the patient had been seen on 8/12/10 and nurse sick call on 8/27/10 and no further treatment is indicated. The HSR was not signed by the staff member. We found no 8/27/10 sick call note in the record.

On 9/30/10 at 1530 the patient was in medical requesting his morning insulin dose which was not given due to syringes not being available. The nurse notified the physician who ordered that the full dose of insulin be given.

Summary: This record demonstrates multiple problems including lack of medication continuity upon arrival, medication transcription errors, lack of timely access to nursing sick call, nurses obstructing access to care by failing to evaluate or refer the patient to the doctor, failure of the doctor to recognize symptoms of serious medical conditions and initiate an appropriate work-up; the medical record is in disarray; lack of medical supplies (e.g. syringes) to administer essential medications; the psychiatrist discontinuing medications upon arrival. The patient had lost 13 lbs since his arrival at the facility.

Patient #6

This 33 year-old arrived at EMCF on 4/15/10. His medical history included a history of mental health and seizure disorder. His medications were Remeron, Wellbutrin, Colace and Fibercon.

Transfer Screening

Upon arrival the receiving screening form was not completed and his medical history is not documented in the record. Staff reported that the patient was known to have a seizure disorder but MDOC did not forward all medical record volumes to EMCF and the current volume (5 of 5) did not contain any information about the patient's history of seizure disorder. It was not apparent that any effort was being made to contact MDOC and have the medical record forwarded to EMCF. The nurse renewed the patient's medications and they were started on 4/17/10.

Mental health

On 5/3/10 the psychiatrist saw the patient and stopped his Wellbutrin and Remeron.

Sick call

28. On 7/20/10 the patient submitted an HSR complaining of having painful breathing, weight loss, lack of energy and numbness. It was received on 7/21/10. On 7/28/10 (7 days) an LPN saw the patient and measured his weight and vital signs. (Wt=151.8 lbs., Temp= 98.6°F, BP=138/84

mm/hg, pulse= 72 beats per minute, his oxygen saturation was abnormally low (93%, normal=>95%. The nurses' plan was to refer to the doctor. This referral did not take place.

On 8/7/10 at 1350 the inmate was brought to medical by security with swelling on the left side of his face and ear swollen and red. He reported that he was dizzy when he stood up and passed out falling to the floor. The dentist saw the patient and believed that his jaw was broken and he was sent to Anderson hospital where he was diagnosed with an occipital skull fracture. He refused further care and at 1745 was discharged back to EMCF where he was admitted to the infirmary. He was prescribed Lortab for pain and it was recommended that the facility physician see him in 24-48 hours.

A nurse initiated an infirmary admission history and physical form with a chief complaint of dizziness and passing out. The nurse also noted the hospital discharge diagnosis of skull fracture.

The physician gave orders that included vital signs every 2 hours and a liquid diet. He discontinued the order for Lortab for pain and wrote an order for Ibuprofen 400 mg twice daily for 3 days. At 2000 the patient complained of severe pain and requested medication. When he learned that the physician had changed his medication from a narcotic to Ibuprofen, he became irate.

The physician later documented that the patient had swelling to the left jaw area and had a *questionable* skull fracture. He wrote that his past medical history was noncontributory. He did not address the precipitating symptoms that led to his fall (e.g. dizziness and syncope) or explore the possibility that his injuries were due to other causes, such as trauma due to excessive force. He wrote that he doubted that the patient had a skull fracture despite the documented discharge diagnosis from the hospital. The doctor discharged the patient from the infirmary without any plans for follow-up.

Although the doctor questioned the patient's diagnosis, the patients CT report that showed he had a skull fracture was faxed to the facility on 8/12/10 and the physician reviewed and signed it on 9/1/10. He did not see the patient following review of the report.

Sick call

29. On 8/28/10 the patient submitted an HSR complaining of having shortness of breath, numbness down his left side, blackouts and migraine headaches. No documentation of when it was received. On 8/31/10 a LVN did not evaluate the patient but referred him directly to the doctor.

On 8/31/10 the doctor saw the patient who complained of headaches, blackouts, left sided numbness and shortness of breath. The doctor did not reference the patients' history of skull fracture or take a history of onset of symptoms. The patient's vital signs and neurological examination were normal. His assessment was no neurological deficit and he prescribed Excedrin for headaches.

On 8/31 his weight was 148 lbs he is 6 feet.

30. On 9/7/10 he submitted an HSR complaining of bad coughing spells, SOB and migraine headaches and passing out. He requested to see a specialist. The form was collected the same day. The nurse wrote that they were out of cough syrup but would be ordered.

On 10/18/10 at 1934 a code blue was called for the inmate. A nurse found him lying on floor and measured his vital signs [BP=176/100 mm/hg, pulse= 78 beat/minute, respirations= 20 breaths/minute, afebrile]. The patient stated complained of dizziness and stated that he fell and hit his head and it felt like something popped in his ear. The patient's left face and jaw area was swollen and red. No other injury noted. The nurse received orders to send the inmate to the local hospital.

At 2300 the patient returned from ARMC; discharge diagnosis was soft tissue injury to his face.

Upon his return it was documented that he refused medical care but would not sign the refusal. The patient was returned to his housing unit. The physician did not see him following his return.

Segregation Rounds

The top portion of his August 2010 segregation round sheet is not completed with respect to admission and discharge dates (as applicable), special diet or medications. Rounds began on 8/27/10, 8/28, none were documented on 8/29-8/31, they were restarted on 9/1 and 9/2 and none thereafter.

Summary: This record is disturbing for many reasons. The patients previous medical records were not transported from MDOC to EMCF and important information such as the patient's history of seizure disorder were not in the current volume. The receiving nurse did not complete the medical transfer form; the psychiatrist discontinued the patient's medications.

The doctor did not appropriately evaluate the patient's symptoms leading to his fall; or consider that the findings of a skull fracture were not consistent with his symptoms. We interviewed this inmate who reported that his injuries were a result of custody staff assaulting him. If it has not already occurred facility leadership and/or MDOC should be investigate this allegation. The doctor also did not monitor the patient at all following his skull fracture. When the patient returned 3 weeks later with neurological symptoms, the physician did not even consider the previous diagnosis of skull fracture in his evaluation of the patient. Following another incident in which the patient was sent to the hospital, the physician did not see the patient.

Segregation rounds are not consistently made and documented in the health record.

Patient #7

This 47 year-old arrived in EMCF on 5/19/10. His medical history included hypertension. His medications include Amlodipine, Enalapril, Atenolol, Lasix, Potassium, Prozac, ASA, Ibuprofen and Colace.

Transfer screening

On 5/19/10 a nurse performed transfer screening and renewed the patient's medications. The medications were started on 5/21/10. Review of the record shows continuity of medications. His weight on arrival is 170 lbs.

Mental Health

On 6/28/10 the psychiatrist saw the patient and discontinued his Prozac.

Chronic disease management

On 5/25/10 the physician saw the patient for chronic disease management. He took a brief medical history. The patient's weight was 164 lbs. His vital signs were normal. He planned to continue medications, ordered labs, EKG, CXR, lipid, CMP and to see the patient 6 months. No labs were drawn. The CXR was obtained on 6/18/10 and reviewed on 6/20/10. The EKG was not obtained as ordered.

On 10/10/10 an EKG was performed showing sinus rhythm and right bundle branch block. The physician reviewed the report on 11/29/10.

On 11/23/10 the physician saw the patient again for chronic disease management. He did not obtain any interval cardiac history (chest pain, shortness of breath). He noted that no labs were available. The patient's vital signs were normal, but his weight was 148 lbs, a loss of 22 lbs since his arrival in May. The doctor assessed the patient's disease as being in good control. He did not address the patient's weight loss. He reordered labs and planned to see the patient in six months. The physician did not write his own orders for renewal of medications, delegating this to the nurses.

Urgent Event

On 12/5/10 at 1845 the patient presented with chest pain during pill call and correctional officers escorted him to the medical section. A nurse obtained 2 serial EKGs showing atrial flutter and QRS contour abnormality consistent with septal infarct. At 1906 a repeat EKG showed sinus rhythm and QRS (T) consistent with septal infarct. The nurse notified the physician who advised to send the patient to the emergency department for evaluation.

There is no further documentation as to when he was sent out to the hospital or when he returned. The patient has not been seen since.

We discussed this case with staff who reported that the patient was sent and admitted to Anderson hospital. There was no medical information related to this admission in the record and the patient has not received appropriate follow-up.

Segregation Rounds

We reviewed a September 2010 Segregation form. The top portion of the form indicating the dates of admission and discharge, diet and medications was not completed.

Segregation rounds began on 9/2/10. Staff did not document rounds on 9/3, 9/7, 9/8, 9/11, 9/12, 9/13, 9/16, 9/17 or 9/17.

Patient #8

This 26 year-old arrived in EMCF on 4/20/10. His medical history included Asthma. He was not taking any medications.

Transfer Screening

Upon arrival a nurse completed the transfer screening process.

Chronic disease management

On 4/27/10 the doctor saw him for chronic disease management. He did not obtain a history of the frequency of asthma symptoms, including most recent episodes; history of hospitalizations or intubation. He noted that the patient used one Albuterol MDI per month and was also taking QVAR. The patient's peak expiratory flow rate (PEFR) was 350 and his weight was 197 lbs. The physician did not assess the patient's level of disease control. His therapeutic goal was "Less asthma". He requested follow-up in 6 months.

On 10/26/10 the doctor saw the patient for follow-up. He noted that he had had 3 asthma attacks since he was last seen and used one albuterol inhaler per month. He did not determine how recent the patient's symptoms occurred, nighttime symptoms or precipitating factors, if any. The patient's PEFR was 400. His weight had declined 16 lbs. (197→181 lbs), but the physician did not note or address this. The physician He inaccurately assessed the level of disease control as being fair and status unchanged from the previous visit.

On 1/25/2011 the doctor saw the patient. He documented that the patient had no noted no asthma attacks since October. He did not inquire about inhaler use. The patient PEFR was 350 and his oxygen saturation was borderline at 95%. He assessed the patient as being in good control. He requested follow-up in 3 months. The doctor delegated writing of medication orders to the nurse.

Sick Call

31. On 11/20/10 the patient submitted an HSR complaining of being sprayed with chemical agents and burning his skin off. He requested help. The form was received on 11/24/10. On 12/1/2010 (4 days) an RN saw the patient and filled out the pepper spray or chemical exposure protocol and ordered triple antibiotic ointment that was not on the protocol. The patient's weight was now 178 lbs., a loss of 19 lbs since his arrival

Summary: The doctor did not obtain adequate baseline or interval asthma histories. He did not address the patient's significant weight loss. This asthma patient was exposed to chemical agents and did not receive timely care.

Patient #9

This 35 year-old arrived at EMCF on 3/30/10. His medical history included asthma and hypertension. His medications were QVAR, Albuterol MDI, Atenolol, HCTZ, and Risperdal.

Transfer screening

Upon arrival a nurse saw the patient and performed intake screening. His medications were reordered upon arrival. The medications were started on 4/2/10 (3 days). His weight was 193 lbs.

Chronic Disease Management

On 4/1/10 the doctor saw him for chronic disease management. He did not perform a review of symptoms related to cardiac disease. His vital signs and PEFR were within normal limits. His weight was 188 lbs (↓ 5 lbs). The physician ordered lab tests (biochemical profile, lipids and urinalysis). He reordered medications and requested follow-up in 6 months.

On 10/5/10 the doctor saw the patient again for chronic disease management. The patient denied chest pain and shortness of breath. He did not inquire about frequency of asthma symptoms or inhaler use. He did not address the patient's medication adherence, however our review of his MARs from April to December show multiple no shows and refusals of medications. The patient's blood pressure was elevated (144/91 mm/hg). Ordered labs were not obtained. The physician accurately assessed patient's poor disease control and added Lisinopril to his medication regimen. However this does not address the primary factor contributing to his poor disease control which was medication noncompliance. The physician ordered labs and requested follow-up in 3 months.

On 1/4/11 the physician saw the patient for follow-up. The patient's weight was 172 lbs. (↓ 21 lbs.). Te patient's labs were not performed as ordered. The physician delegated writing of medication orders to the nurse.

Summary: The physician did not address the primary reason for the patient's poor hypertension disease control and his 21 lbs. weight loss. The physician has not adequately addressed the problem of labs not being available. One of the consequences is that the physician has not evaluated and addressed important cardiovascular risk factors such as cholesterol.

Patient #10

This 25 year-old arrived at EMCF on 10/20/09. His medical history included mental health issues. His medications were Risperdal, Depakote and Cogentin. The medication order was not cosigned by the doctor. His medications were started the following day.

Transfer Screening

Upon arrival a nurse completed the screening process. His blood pressure was elevated (BP=146/95 mm/hg.) His weight was 169 lbs. on 10/5/2010.

Mental Health

On 12/14/09 the psychiatrist stopped his medication due to noncompliance.

32. On 5/14/2010 he submitted an HSR complaining of not being able to eat anything because his right jaw locks up and he could not chew. The form was received on 5/16/2010. On 5/27/10 an LVN saw the patient and noted that the right side of his jaw appeared to pop out of place at will. The nurse referred the patient to the physician but it did not take place.

33. On 11/1/10 the patient submitted an HSR complaining of needing to have surgery on his wisdom and another tooth that is decaying. He requested dental services. This was received the same day and on 11/4/10 the nurse saw the patient, noting his bottom wisdom tooth had a hole in it. No infection noted. The dentist saw the patient on 11/13/10 and prescribed Clindamycin and Motrin. He has not been seen since.

On 12/12/10 the patient wrote to the HSA stating that it had been over a year since he was to have surgery on his wisdom tooth and he has been unable to eat due to pain. He requested that something be done.

Summary: When the nurse referred the patient to the physician, the referral did not take place. Dental services have not been provided in a timely manner.

Executive Summary

In summary, following my review of selected areas of the EMCF health care program I make the following conclusions:

- Inmates do not have timely access to appropriate medical care.
- Staff does not document medical care in the health record in accordance with community standards.
- Health care policies and procedures do not provide sufficient operational guidance with staff.
- Patients with chronic illnesses are not being monitored in accordance with recognized guidelines and the frequency of monitoring does not occur in accordance with the patient's degree of disease control (i.e. poorly controlled patients are monitored at greater frequency than well controlled patients).
- Based upon its the size and health care and security missions, the facility has insufficient numbers of health care staff to provide appropriate and timely health are to inmates with serious medical conditions.
- There are serious problems with medication administration including lack of continuity of medications for serious medical conditions; medication errors; inappropriate crushing of medications; and medication administration process that fails to meet accepted nursing practice standards.
- The physician does not have the requisite training and credentialing to provide primary care to the patient population demonstrated by his failure to recognize and treat patients with symptoms of serious medical conditions. The physician also does not adequately treat patients with moderate to severe, acute pain.
- The facility does not have an adequately functioning CQI program at this time. GEO's clinical performance review program has not resulted in the removal of physicians who provide inappropriate medical and mental health care.
- Based upon our findings, inmates are subject to significant, undesired weight loss due to inadequate medical evaluation and insufficient caloric needs.
- Record reviews suggest that correctional officers exert excessive force through the use of chemical restraints (e.g. pepper spray) and/or physical force.

Recommendations

Access to Care

1. MDOC/GEO should ensure that inmates have continuous access to health care request forms.

2. Inmates must be able to confidentially submit health care request forms into locked boxes that are accessed only by health care staff.

3. Health care staff should collect the forms 7 days a week. Registered nurses should triage the forms within 24 hours of receipt to assess the nature and urgency of the complaint.

4. Following triage, nurses should schedule patients to be seen at sick all within 24 hours (72 hours on weekends).

5. Only a registered nurse or higher level provider should perform patient assessments. LPNs should not be assigned this responsibility due to their lack of training.

6. The physician should be immediately removed from the facility and replaced with a physician trained and credentialed in primary care (e.g., family practice, internal medicine).

7. Health care staff should conduct and document daily rounds in segregation.

8. Health care leadership should ensure more timely access to dental services. Nursing staff should triage dental health requests and assess patients who complain of pain and/or infection.

9. Facility leadership should ensure adequate correctional officer staffing on segregation units so that inmates can notify them in the event of a medical emergency.

10. Health care leadership should conduct CQI studies of the access to care process to identify issues and develop strategies for improvement.

Health Records

11. When MDOC transfers inmates to EMCF, all volumes of the health record should be forwarded at the time of transfer.

12. MDOC/GEO should ensure that policies adequately address health record organization and that the facility adheres to the policy. Policy should clarify where dental records and diabetic flow sheets should be filed.

13. Health care leadership should ensure that there is a system for tracking, reviewing and filing hospital reports and other health record documents.

14. GEO should assess health record staffing to ensure that there are adequate resources to file health records in a timely manner.

15. Health care staff should contemporaneously document all clinical encounters.

Policies and Procedures

16. GEO should update its corporate policies and procedures.

17. EMCF should develop site specific policies to provide sufficient operational guidance to staff. These policies should be reviewed and updated annually or as needed when policy changes are made.

18. The site specific policy of crushing all medications should be changed so that crushing medications is patient specific, and in response to a legitimate clinical basis, such as difficulty swallowing or hoarding medications.

Chronic Disease Management

19. GEO should only hire primary care trained and credentialed clinicians to treat patients with chronic diseases.

20. Clinicians should provide medical care that meets nationally recognized clinical guidelines, including ordering appropriate labs, performing eye examinations for diabetics and offering recommended vaccinations.

21. The health care administrator should that a system for ordering and completing laboratory tests is functional as well as the system for reviewing and filing of laboratory reports.

22. Clinicians should review medication administration records at each clinic visit to evaluate the role of adherence in whether patients are well or poorly controlled.

Staffing

23. Clinician staffing should be increased to meet the unmet clinical demands at the facility. GEO should consider adding a full time nurse practitioner.

24. Nurse staffing should be adjusted to add sufficient number of registered nurses to perform sick call and other responsibilities that involve making independent nursing assessments. LPN staffing should be adjusted to enable medications to be administered in a timely manner. Consider adding a Director of Nurses position

25. Ancillary staffing should be evaluated and adjusted to provide adequate support services.

26. Dental staffing should be assessed to ensure timely and appropriate access to care.

Pharmacy and Medication Services

27. GEO should negotiate the order cutoff date with CorrectRx to reduce the volume of nurse transcribed medication orders.

28. Physicians should write their own medications orders except when nurses accept verbal and or telephone orders. All medications orders should be signed by a physician in a timely manner.

29. Nurses should request, and inmates should be required to present identification badges to receive medications.

30. Nurses should administer medications only from properly labeled pharmacy dispensed packages. No loose medications should be kept in the medication cart.

31. Medication administration should be a collaborative effort between nurses and correctional officers. Officers should ensure the orderly flow of inmates to the window; that inmates have their identification badges with them; that inmates take their medications immediately; and perform oral cavity checks with a penlight to ensure that medications have been swallowed.

32. Health care leadership should evaluate and address the reasons for lack of medication continuity.

33. Nurses should report patient medication noncompliance to the physician in a timely manner.

Quality Improvement Studies and Clinical Performance Review

34. The Health Care Administrator should initiate a multidisciplinary CQI program focusing on problematic areas of health care delivery.

35. Following clinical performance review, GEO should immediately remove clinicians who are identified as dangerous or providing care that is well below the community standard of care.

Excessive Force and Unintended Weight Loss

36. Facility leadership should investigate reports of excessive force identified in this report including excessive use of chemical restraints.

37. Custody staff should contact health care staff prior to the use of chemical restraints to identify patients for whom chemical restraints are contraindicated.

38. MDOC/GEO Leadership should initiate an evaluation of dietary/nutritional requirements and ensure that inmate menus are adequate to meet inmate daily caloric requirements. In addition, food should be served at proper temperatures.

Respectfully Submitted,

_____ February 25, 2011

Madeleine LaMarre Date

The opinions expressed in this report are based on the information currently available to me. If additional information is brought to my attention (for example, additional documents or depositions), I may amend or supplement my opinions.

Appendix A – Patient ID Numbers

Patient Number	Name	Inmate ID
Patient #1	[redacted]	[redacted]
Patient #2	[redacted]	[redacted]
Patient #3	[redacted]	[redacted]
Patient #4	[redacted]	[redacted]
Patient #5	[redacted]	[redacted]
Patient #6	[redacted]	[redacted]
Patient #7	[redacted]	[redacted]
Patient #8	[redacted]	[redacted]
Patient #9	[redacted]	[redacted]
Patient #10	[redacted]	[redacted]

Exhibit 3

Eastern Mississippi Correctional Facility (EMCF) Report

Submitted
June 16, 2014

Submitted by
Madeleine L. LaMarre MN, FNP-BC

Contents

Qualifications

I, Madeleine LaMarre, MN, FNP-BC have been retained by Plaintiffs' counsel as a correctional and nurse practitioner expert to review health care services at the Eastern Mississippi Correctional Facility. Compensation for my work is being billed at $250 per hour and ½ my hourly rate for travel time, and $250 per hour for deposition or court appearances. In the following paragraphs I have summarized my background and experience in correctional health care as a prelude to this report.

I have practiced nursing for 30 years. I am a registered nurse and certified family nurse practitioner. Since 2005, I have been self-employed as a correctional health care consultant primarily involved in monitoring prison and jail compliance with settlement agreements, and providing technical assistance to correctional agencies to improve the quality of health care services and clinical outcomes.

My experience in corrections began in 1982, when I worked as a nurse practitioner/ administrator at the Atlanta Transitional Center, which is a Georgia Department of Corrections (GDC) facility. In 1984, I joined the GDC Office of Health Services full-time as a Nurse Consultant. My responsibilities within the agency grew over time and in 1995, I became the Statewide Clinical Services Manager. My responsibilities included the development of administrative policies regarding health care delivery; clinical guidelines including the treatment of HIV and hepatitis C infection and other communicable and chronic diseases. I provided training to GDC health care staff regarding policies and clinical guidelines. I was also responsible for a clinical auditing process that surveyed health care at over 40 correctional institutions, providing consultation to clinicians and nurses to improve health care delivery and patient outcomes. I have authored or coauthored a number of publications, and was an associate editor for a textbook on correctional medicine, Clinical Practice in Correctional Medicine, 2nd edition by Michael Puisis published in 2006. I am a member of the American Nurses Association, American Association of Nurse Practitioners, and the Academy of Correctional Health Professionals.

In 2002, I was appointed by Judge Thelton Henderson to be a medical expert in the Plata v. Schwarzenegger case. This was followed by appointments as a health care monitor for other cases and at the end of 2004 I left the Georgia Department of Corrections to pursue this work full time. I am familiar with standards of nursing practice and correctional health care.

Document Review

I reviewed the following documents for this report.

1. Class Action Complaint. Jermaine Dockery et al. v. Christopher Epps et al. Civil Action No: 3:13CV326TSL-JMR. United States District Court. Southern District of Mississippi, Jackson Division. May 30, 2013.
2. MDOC Health Care Policies and Procedures
3. Health Assurance LLC (HALLC) Medical Services Policies and Procedures, 2009.
4. National Commission on Correctional Health Care (NCCHC) Standards for Health Care Services in Prisons. 2008.
5. Eastern Mississippi Correctional Facility Report. Madeleine L. LaMarre MN, FNP-BC. Presley v. Epps, No. 4/05-c-00148-DAS-(ND. Miss. Nov 8, 2011). DOC. No. 151-8.
6. HALLC Staffing Matrix, as of 11/12/2012. HALLC Staff 2-3.
7. Sick Call Request Log. HALLC Med Care 2.
8. Sick Call Request Log-Eye Complaints-HALLC Eye 2.
9. Sick Call Request Log-Dental Complaints. HALLC 2-33.
10. Medical Admission Infirmary Log. HALLC Adm Log 1-42.
11. Hospital Admissions. HALLC ER 2-17.
12. Hospital Admissions. HALLC ER 18-23.
13. Health Assurance Employees. July 19, 2012 to present. HALLC Emp 2-5.
14. Listing of Inmates who engaged in Self Harm. EMCF. HALLC SH 2.
15. EMCF Deaths in Custody 1/1/2011 thru 10/2/2013.
16. MDOC Use of Force Policy SOP 16-13-01. 7/19/2013.
17. Expert report of Marc Stern MD. Eastern Mississippi Correctional Facility.
18. Expert report of Terry Kupers MD. Eastern Mississippi Correctional Facility
19. West Mississippi's Administrative Code. Advanced Practice Registered Nurses Practice Requirements. 30-18-2840:2.3.
20. Titus Snell Resume and Certificates.
21. Ophthalmology Technician Service Agreement.
22. Health Assurance Job Descriptions.

Overview

On April 22- 25, 2014 I visited the East Mississippi Correctional Facility (EMCF) in Meridian, Mississippi. The purpose of the visit was to assess whether EMCF inmates received adequate health care for their serious medical and mental health conditions.

I was accompanied by Marc Stern, MD, correctional medical expert, Terry Kupers, MD, correctional psychiatric expert, Bart Alplanalp, mental health consultant, Margaret Winters, Gabriel Eber of the ACLU, Jody Owens, Elissa Johnson and Alesha Judkins of the Southern Poverty Law Center (SPLC).

I performed the following activities in preparation for and during the site visit:

- Reviewed the class action complaint alleging inadequate medical and mental health care at EMCF
- Toured EMCF inmate housing units, main and satellite medical clinics
- Interviewed health care and custody staff
- Observed medication administration by nursing personnel
- Reviewed health records and other medically related documents
- Spoke with inmates

I would like to thank Warden Jerry Buscher and HALLC staff for their assistance in conducting this review.

EMCF is a privately owned facility operated by Management Training Corporation (MTC). The facility has an authorized capacity of 1362 inmates, expandable to 1500 inmates.[1] Medical Care is provided by Health Assurances, LLC (HALLC) The facility has a specialized mission of providing psychiatric services and individualized and group counseling.

[1] Mississippi Department of Corrections website. Updated 5/1/2014.

Executive Summary

The Mississippi Department of Corrections has chosen to concentrate a large population of seriously mentally ill inmates, many of whom also have serious medical illnesses, at Eastern Mississippi Correctional Facility (EMCF). Providing adequate health care for this high-acuity medically and mentally ill population requires that EMCF have an adequate structure for providing health care services, including health care policies and procedures; adequate numbers and types of staff; staff training; and a quality improvement program designed to identify, study and implement strategies to correct problems. In addition, an adequate health care delivery system requires that the components of a health care system function in an integrated manner.

However, my review of EMCF shows that virtually all EMCF health care systems are broken or dysfunctional, resulting in actual and ongoing risk of harm to patients. These systems include access to care, medication administration, chronic disease management, specialty services and infirmary care. My review of health records shows that medical provider and nursing evaluations are grossly inadequate, and in some cases demonstrate deliberate indifference to the serious medical needs of patients. My findings show that harm is pervasive and includes the following examples:

- A 25 year-old patient with metastatic testicular cancer that did not have timely access to a urologist following an abnormal ultrasound that show testicular mass.
- A 31 year-old patient with a brain tumor who has not received timely CT scan and referral to a neurosurgeon.
- A 64 year-old patient with undiagnosed and untreated diabetes who reports losing his vision and has not received an ophthalmological evaluation and referral to a retinal specialist.
- A 28 year-old patient with bilateral glaucoma who was blind in his left eye, and lost vision in his right eye because he did not receive his glaucoma medications.
- A 40 year-old asthma patient sent to the emergency department and/or hospitalized 7 times in 3 months partly due to not receiving his medication.
- A 33 year-old asthma patient hospitalized three times from January to June 2013. The patient also has left eye blindness and blurriness and pain in his right eye and has not received an ophthalmological evaluation.
- A 36 year-old patient diagnosed with early glaucoma in May 2012 who had not received glaucoma medications and as of April 2014 has had no further follow-up.
- A 53 year-old poorly-controlled diabetic with diabetic retinopathy and glaucoma who has not received ophthalmological follow-up or glaucoma medications.
- A 55 year-old patient with subdural hematoma following correctional officer use of force who did not received recommended MRI and neurology follow-up.
- A 70 year-old patient with prostate cancer who did not receive urology follow-up and for whom EMCF providers are unaware of August 2013 bone scan and oncology radiation recommendations.

Two cases warrant particular comment. In the case of a 25 year old with metastatic testicular cancer, the physician was aware of the patient's ultrasound showing a testicular mass, but did not

respond to the patient's requests to discuss the ultrasound report despite the patient's repeated requests. I find this to be shocking and cruel.

In the second case, a 55 year old patient with long standing psychosis and delusions was subject to a use of force by correctional officers that resulted in head trauma and bleeding in the brain. Following the use of force, the physician did not document any examination of the patient. He placed the patient in a medical observation room that did not have a toilet where he remained for 6 days before being moved to an infirmary bed. Over the course of 10 days the patient's mental and physical condition deteriorated until he was unable to feed himself and was incontinent of bladder and bowels. The physician and nurses did not monitor the patient for neurological changes at any point during this time, and it was not until he had repeated seizures that he was sent to the hospital and diagnosed with a subdural hematoma from head trauma. Following the patients' return to the facility, the physician did not see the patient.

Patients with serious eye disease are not being evaluated and treated by a qualified health care provider and are not receiving adequate treatment and follow-up. HALLC has contracted with an optician to perform optometry services. An optician is not trained and licensed to evaluate and treat patients with eye diseases. Staff refers to him as "Doctor" yet review of his credentials does not show he is licensed as any kind of doctor. We found multiple cases of patients with glaucoma and other serious eye diseases who are not receiving appropriate care and have lost vision.

In 2011, I prepared a report on health care at EMCF pursuant to the provisions of the settlement agreement in Presley v. Epps, No. 4:05-cv-00148. At that time, I found pervasive deficiencies in health care at EMCF that I would have expected MDOC to address the profound problems I found. Apparently the officials of the Mississippi Department of Corrections did not challenge my conclusions about health care at EMCF, as I understand that they cited it in informing the previous contractor that these deficiencies violated their contract to operate the facility.

Unfortunately, as this report makes obvious, my previous review with accompanying recommendations did not lead to reform of the systemic deficiencies in medical care at EMCF. I found then, as I find now, that responses to inmate health requests are not timely and often result in no meaningful care. Similarly, then and now I found deficiencies in the performances of health care staff resulted in actual and ongoing risk of harm to patients. Then and now I found problems with insufficient numbers of staff, some lacking necessary training and credentialing to treat patients, resulting in grave harm. Then and now I found that medication administration does not follow standards of nursing practice required for patient safety and patients with serious medical conditions do not receive their medications. Then and now I found problems with chronic disease management, including provider failure to perform adequate assessments and monitor patients in accordance with their disease control. Then and now I found serious problems with the maintenance of the medical records. Disturbingly there is no evidence of MDOC ownership and oversight of health care provided to patients at this facility, as shown by the lack of any meaningful quality improvement or external monitoring program; if there were such oversight, these problems could not exist to this magnitude.

The most significant difference between my review in 2011 and now are that conditions are worse, and the risk of harm to patients has increased.

Policies and Procedures

MDOC and Health Assurances policies and procedures are neither current nor specific to EMCF and therefore do not provide adequate operational guidance to health care staff.

I reviewed MDOC and HALLC policies and procedures. The MDOC health care policies were last reviewed in 2004 and 2008. The HALLC medical policies and procedures were last reviewed in October 2009. This is prior to HALLC providing health care services at EMCF and the policies do not provide operational guidance to EMCF staff.

Moreover, MDOC and HALLC corporate health care policies and procedures reference American Correctional Association (ACA) standards and National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Prisons as the applicable standards but their policies and procedures do not meet the standards, and even when they do meet NCCHC standards, they are not compliant with their own policy.

For example, the NCCHC standard regarding Policies and Procedures (P-A-05) requires that responsible health authority review the policies annually and revise them as necessary. The policy manual is to bear the date of the most recent review and the signatures of the facility responsible health authority and responsible physician. The MDOC and HALLC policy and procedures also require annual policy review and revision, but neither set of policies has been reviewed in the past 4 years, and thus they are not compliant with their own policy.

Among MDOC and HALLC policies and procedures that are not compliant with NCCHC standards are those regarding Access to Care, Chronic Disease Management and Infirmary Care.

HALLC policy and procedure regarding Access to Care is based upon two NCCHC standards (P-A-01 and P-E-07) but in fact is not in compliance with the standards. The applicable NCCHC standard (P-E-07) states that staff reviews health requests within 24 hours of receipt and schedules nonemergency requests within the next 24 hours (72 hours on weekends). The HALLC policy states that if an appointment is required it will be scheduled within 7 days of triage. This is not timely care.

The HALLC chronic disease policy does not provide any guidelines for timeliness of scheduling initial and follow-up appointments. The policy states that the frequency of visits will be based upon the severity of the patient's condition and whether it is improving, stable or deteriorating but there are no procedures specific to EMCC to provide staff guidance to implement the policy.

Access to Care

To review access to care, I toured housing units; main and satellite medical clinics, reviewed health records, interviewed custody and health care staff, and spoke with inmates. My review showed that at EMCF inmates do not have timely or appropriate access to care. A registered nurse conducts sick call two times per week for each housing unit which does not meet NCCHC standards to schedule patients within 24 hours of when nurses triage health requests. In addition I found that nursing assessments were almost universally inadequate and referrals to providers do not occur in a timely manner. I also found that nurses exceed their scope of practice by

ordering x-rays without a physician order. The frequency of sick call, lack of successful referrals, combined with nurses exceeding their scope of practice suggests lack of adequate nurse and clinical staffing at EMCF.

For routine access to care EMCF inmates submit a medical services request (MSR) form in secure boxes accessed only by health care staff. Health care staff is to collect and date-stamp the forms daily. A registered nurse is to triage the urgency of each request (urgent or routine) and schedule the patient to see a nurse in accordance with the urgency of the request. Following evaluation, the nurse may treat according to a nursing protocol or refer the patient to a physician or nurse practitioner.

During tours of the housing units I found that inmates were aware of the procedure for accessing sick call and correctional officers had blank health service request forms, except in Unit 6D. However, although inmates report having access to medical request forms, they report that staff does not see them in a timely manner following submission of their request. This was substantiated by record reviews.

For access to urgent care, inmates are to inform an officer who is to notify health care staff to evaluate the patient. If inmates are locked in their cells they are supposed to be able to push an alert button to notify the officer in the control station (the picket) of the need for assistance. However, we found that not all rooms had functional alert buttons. In housing unit 3A we found that two of three cells had non-functional buttons. In housing unit 3C two of two cells had functioning buttons. In housing unit 6D we found that one room (104) did not have a button; two rooms functioned properly (102 and 109) and in two rooms (101 and 107) the light kept flashing and the officer could not turn it off. When we discussed the nonfunctioning alert buttons with staff, they reported that inmates yell to get the attention of correctional staff. A Captain reported that it was a very old system that sometimes malfunctions. This is not a reliable system to ensure timely access for inmates with urgent conditions and inmates report that correctional officers do not respond when they push alert buttons.[2]

Record review also demonstrated that EMCF patients do not have timely access to care for their serious medical conditions and in accordance with NCCHC standards, HALLC policies and procedures and as clinically indicated. Examples of delayed access to care are described below.

A 25 year-old man arrived at MDOC through CMCF on 9/17/2010 and transferred to EMCF on 10/29/10.[3] His medical diagnoses include spina bifida, syncope versus seizure disorder, substance abuse and depression. His admission history and physical was unremarkable but did not include a genital examination.

On 8/8/12 the physician saw the patient noting that he had progressive pain in his right testicle for over two months.[4] According to the physician's note, the patient was seen by another physician and ultrasound was ordered but not completed. His examination showed tenderness of

[2] Terry Kupers MD Expert Report.
[3] Patient #17.
[4] The patient's medical record appears to be incomplete as the physician references encounters that are not in the provided medical records.

the right testicle with radiation to the inguinal area with soft mass-like effect. His diagnosis was epididymitis and he treated the patient with doxycycline and ibuprofen. He planned to have the patient return in one week and schedule the ultrasound on the next visit. However, it appears that the physician did not enter and authorize the medications in the EMR so that the order could be forwarded to the pharmacy and filled. On 8/10/12 a RN reentered the medications but the order was not countersigned by the physician. On 8/15/12 another nurse entered the medication orders but again it was not countersigned by a physician. The patient did not receive his medications.

On 8/20/12 the physician saw the patient and noted that he had not received his medications and still had intermittent pain. He did not document an examination other than to note "no change". Epididymitis. Will start medications as ordered.

On 9/5/12 the patient submitted a health care request regarding his testicle and a RN saw the patient. The patient reported that he was seen in July for swelling of his testicles and completed medications but his testicles are still swollen. The nurse did not examine the patient but referred him to the physician.

On 9/6/12 the physician saw the patient noting that he has had testicular pain and swelling since June 1, 2012. The patient was not improved after antibiotics and has continued swelling. He noted that his left testicle was firm and tender on the left side. He did not examine the right, affected testicle. He planned to schedule the ultrasound and to have the patient return when completed.

On 9/24/12 the patient underwent scrotal ultrasound for right testicular pain and a mass that was consistent with a neoplastic process. The radiologist contacted the EMCF physician the same day and discussed the findings but the physician did not see the patient or document the phone call with the radiologist.

On 9/26/12 the physician electronically signed the ultrasound report. Another copy was signed on 10/17/12.

On 10/3/12 the patient submitted a request stating that he had an ultrasound on 9/24/12 and had not yet received results. On 10/4/12 a nurse documented referral to the physician. The physician did not see the patient.

On 10/13/12 the patient submitted another request stating that he had an ultrasound and had not seen the doctor. He was experiencing extreme pain. The form is not signed and dated as being received by EMCF health care staff and no plan is documented on the form.

On 10/14/12 the patient wrote to the Warden stating that he had been having problems getting medical treatment. He has had an enlarged testicle with "knots on it" since June 1, 2012. He was finally able to get an ultrasound on 9/24/12 but despite constant pain had not been able to see the doctor to find out the results. He felt that he was getting "the runaround' and he feared losing his right testicle "because now over ¾ of it was hard as a rock". He asked the warden for help. A note at the bottom of the form indicated that he was scheduled for surgery.

On 10/17/12 an LPN received a complaint (ARP) from the patient regarding not getting his ultrasound test results. The nurse documented she could not find the report in the record and contacted the radiologist on 10/16/12 and noted the findings suggesting neoplasm. The nurse reported this to the physician. In a separate note the LPN said that she found the report in the record but that the physician did not electronically sign the report until that day. The patient was upset because he has not received pain medication. The nurse added ultram and ibuprofen to the order that was electronically signed by the physician.

On 10/26/12 the patient underwent a right radical orchiectomy and the pathology report confirmed cancer. On 10/29/12 the physician wrote a note that the patient had surgery and it was uncomplicated. There is no subjective or objective documentation to suggest he saw the patient.

On 11/1/12 the patient saw the urologist for follow-up and a follow-up CT scans showed that he had an enlarged retroperitoneal lymph node. The physician did not date and sign the report.

On 11/7/12 the physician wrote a progress note but it is unclear whether he saw the patient. There are no objective data except: good, no distress at this time.

In December 2012 the patient started chemotherapy and on 12/26/14 he transferred to CMCF.

Assessment: It appears that documents are missing from this patient's health record, including any health requests that the patient forwarded after he found a right testicular mass and from the other physician who ordered an ultrasound. However, the available documentation shows that the physician was shockingly and deliberately indifferent to the patient's symptoms and diagnosis of testicular cancer. The patient's care was delayed and he has metastasis requiring chemotherapy. On 9/24/12 the radiologist called Dr. Faulks to inform him of the ultrasound report and thereafter, medical record documentation suggests that the physician never saw the patient to discuss the ultrasound results and plan of care. It is unclear from the physician's scanty documentation whether he saw the patient after his surgery to ensure that the patient was healing properly.

In another case, a 36 year-old man transferred to EMCF on 11/5/13.[5] His medical history includes psychosis and alcohol abuse. Of concern is that the patient has documented 25 lbs. weight loss (145 lbs to 119 lbs.) over two years, but has not been medically evaluated for weight loss. Shortly after arrival the patient complained of a severe cold. On two separate occasions, nurses did not perform any assessment of the patient but treated him with over-the-counter medication. The patient did not improve and a month later the physician saw him but did not note or address the patient's weight loss or respiratory symptoms lasting a month. He treated the patient with an antibiotic but ordered no follow-up to determine if he improved. A cough lasting >3 weeks plus weight loss warrants a medical evaluation for tuberculosis and other serious medical conditions. Another potential cause of the patient's weight loss is his dental condition. On 11/15/13 the dentist documented that the patient was missing 15 of 32 teeth and noted he needed upper and lower partials. On 12/10/13 the patient reported being unable to chew his food due to missing teeth and he requested partial plates. On 1/12/14 the dentist documented that

[5] Patient #4.

partials were "not indicated" although the patient is missing half of his teeth. The dentist did not clinically evaluate the patient to even assess his ability to chew food and whether he had weight loss that may have medically justified partial plates or a soft diet. The dentist also did not meet with or communicate with the patient regarding his decision. Having heard nothing, the patient submitted another health request; however the dentist did not see the patient but simply charged him $6.00. Charging the patient without seeing him is callous disregard.

Assessment: This patient has not had timely and appropriate evaluation of his 25 pound weight loss.

In another case a 31 year-old man arrived at CMCF on 9/4/13 and transferred to EMCF on 10/3/13.[6] His medical history includes mild mental retardation, seizure disorder, brain tumor, asthma, diabetes, a "heart condition", psychosis and depression. Upon arrival at CMCF staff noted that he had a brain tumor and obtained copies of his medical records that were scanned into the record on 9/5/13. When he transferred to EMCF the patient requested to see the physician about his brain tumor. The patient submitted a request to see the doctor for a brain tumor, blood clots in legs and arms and also needing a snack bag, because he was hungry. On 10/9/13 the nurse saw the patient. The nurse did not take any history of the patient's complaint. His weight was 146 lbs. and vital signs were normal. The patient reported: "I have a brain tumor and blood clots in my arms and legs. I got hit by a truck." Under objective the nurse documented, "This inmate has a wild story to tell and I am not sure what happened or when. He does have several physical issue and some mental issues." The plan was muscle rub, ibuprofen and shampoo. The nurse did not perform a review of systems (e.g., headache, weakness, etc.) or explore the patient's history to obtain more information about the patient's reported history of blood clots; or document a referral to the provider. This was not an appropriate assessment. On 10/11/13 the physician saw the patient but did not inquire about neurological symptoms or address the patient's other chronic diseases. He planned to obtain his previous medical records, not realizing the patient's South Central Hospital records were already in the medical record. The physician did not see the patient again for follow-up of his brain tumor until 3/3/14, almost five months after the initial visit. At that time the patient reported intermittent headaches with facial numbness and balance problems. The physician again documented a plan to obtain previous medical records and order a brain CT.

On 3/14/14 the patient submitted a request for abdominal pain. On 3/17/17 the nurse saw the patient. The nurse noted medical history that indicated that he had abdominal surgery and that the patient "states that he had his hemorrhoids removed and half his colon in 2010 in Hattiesburg". The nurse documented that she was unable to verify the information in the EMR. The nurse performed no examination. The nurse planned to request x-rays of his abdomen and colon; and informed him to eat small bites and chew his food well. The nurse did not document notifying a provider and did not obtain an order for an abdominal x-ray. On 3/19/14 the radiologist performed an abdominal x-ray noting that there was no ordering provider information or reason for x-ray.

Assessment: As of the time of our visit on 4/23/14, the patient had not had the CT scan or further medical follow-up for his brain tumor. The nurse performed an inadequate assessment for

[6] Patient #2.

abdominal pain and ordered an x-ray without a physician order which exceeds the nurses' scope of practice. The radiologist performed the x-ray without a physician order.

We also found cases in which patients are not provided timely access for conditions that threaten life and limb. A 25 year-old man transferred to EMCF in 2011.[7] On Friday, 6/21/13 a nurse practitioner saw the patient who complained of waking up the day before with a painful, hot, swollen left hand. The patient had a fever of 100.4^0F. His hand was warm, edematous and he was unable to move all five fingers. The NP ordered antibiotics but we found no documentation in the record to show he received the antibiotics. On Sunday 6/23/13 a different NP saw the patient noting that the patient's hand infection had extended to the patient's elbow. He had a fever (T=102.3^0F) and rapid pulse (Pulse=125/minute). The NP sent the patient to the hospital where a surgeon found severe infection involving at least three separate areas: the left upper extremity hand, forearm and elbow. The surgeon discussed with the patient the possibility of losing a limb and he underwent two surgeries while hospitalized. On 6/28/13 the patient was transferred directly to MSP for continued care with antibiotics.

Assessment: This patient did not have timely care for a serious infection that put him at risk for losing his arm.

I also found that patients' did not receive timely care for dental pain and infection. I reviewed a sick call log of dental complaints from July 2012 to October 2013.[8] The log includes the date of the request, inmates name and ID, nature of complaint, and date the patient was scheduled and the date the patient was seen. From January 2013 to October 2013 the majority of entries have no date scheduled and no date seen. For all intents and purposes, the dental sick call log is not an effective tool for tracking and ensuring that patients with dental pain and infection are seen in a timely manner.

A 54 year-old man transferred from CMCF to EMCF on 10/9/13. His medical history includes schizophrenia, depressive disorder, diabetes mellitus, and hypertension. He submitted the following requests:

- On 10/31/13 he submitted a request complaining of severe dental pain that was received the next day. A nurse did not see the patient to assess the severity of his pain and determine the urgency of the dental referral. On 11/20/13, three weeks, later the dentist saw the patient and extracted his tooth.

- On 12/1/13 the patient submitted a request indicating he had his tooth pulled and now he had a jaw infection. He requested antibiotics. On 12/4/13 a RN received and triaged the form and referred the patient to a provider but the appointment did not take place.

- On 12/9/13 the patient submitted another request complaining of needing another tooth pulled. A nurse did not see the patient. On 12/15/13 (15 days from his initial complaint) the dentist saw the patient and extracted tooth #4. The dentist ordered antibiotics and analgesia.

[7] Patient #3.
[8] HALLC dental 2-33.

- On 2/1/14 the patient submitted a MSRF for a facial cyst "as big as a baseball". A nurse did not see the patient. In the meantime, on 2/5/14 the physician saw the patient urgently and performed incision and drainage on the facial cyst. He did not order a follow-up visit to determine if the patient if the patient's condition improved. When a nurse did see the patient on 2/11/13 the patient reported fluid collected in the same location as the I&D. The nurse did not take vital signs or describe the patient's wound.

Assessment: This patient did not receive timely care for his dental pain and infection.

Patients also do not receive timely care for treatment of skin and wound infections.[9]

Chronic Disease Management

Chronic disease management was evaluated by reviewing applicable HALLC policies and procedures, tracking logs and health records.

My review showed that chronic disease tracking systems are inadequate and physicians and nurse practitioners do not see EMCF patients in a timely manner following their arrival at the facility and on an ongoing basis. When providers see patients they do not perform adequate evaluations including review of systems (e.g., chest pain, shortness of breath) that are pertinent to the patient's chronic diseases; reference and address laboratory tests; assess the patient's disease control; and document a plan specific to the patient's needs, including follow-up appointments. Physical examinations are almost always documented as being completely normal which raises questions about the thoroughness and accuracy of the examinations. Medical record documentation and poor disease control suggest that patients are not receiving their medications, but medication administration records have not been scanned into the record since October 2013 and it is not possible to accurately evaluate the extent to which medication discontinuity contributes to poor disease control. Cases describing these problems are documented below.

Inadequate Diabetes and Hypertension Care

In an egregious example, a 64 year-old man with schizophrenia and TB infection arrived at EMCF in 2011.[10] On 9/9/12 a physician[11] performed a physical examination and ordered labs that showed the patient had previously undiagnosed and poorly controlled diabetes.[12] The physician did not review the patient's lab reports or see the patient for follow-up, and as of our review in April 2014 the patient's diabetes is undiagnosed and untreated. Moreover, on 1/29/13

[9] Patient #10.
[10] Patient #15.
[11] This physician no longer works at the facility.
[12] On 9/12/12 the patient's blood sugar was 345, a random sugar >200 is diagnostic for diabetes. On 9/26/12 the patient's hemoglobin A1C showed his diabetes was poorly controlled (HbA1C=11.1%, nondiabetic =<6.5%). These lab reports were reviewed on-site but not provided in requested medical records.

the patient submitted a health request stating he was going blind. Health care staff documented no response to him other than to note that he was being charged $6.00. On 3/7/13 an optician performed an optometry examination.[13] The patient's visual acuity was so severely decreased that he was only able to count fingers. The optician referred the patient to an ophthalmologist but the appointment did not occur and he has had no further medical follow-up.

Assessment: Poorly controlled diabetes leads to heart attack and kidney failure. It is also the leading cause of blindness. This patient has had undiagnosed and untreated diabetes for at least 18 months and is losing his vision. We reported this case to the Health Services Administrator prior to leaving the institution on 4/25/14. However As of 5/15/14 there is no documentation in the record that the patient has been medically evaluated.

In another case, a 47 year-old man transferred from CMCF to EMCF on 2/10/14.[14] His medical history included diabetes, hypertension, asthma, latent TB infection, and adjustment disorder. An EMCF nurse did not medically screen the patient on the day of arrival. His chronic disease medications were not renewed. That night at 0025 a nurse checked the patient's blood sugar. It was so high the glucometer machine could not measure it. The nurse called the physician three times for insulin orders to lower the patient's blood sugar. The patient's hypertension was also poorly controlled (BP=152/90 mmHg).

On 2/11/14 a nurse medically screened the patient. The nurse did not recheck the patient's blood sugar or perform peak expiratory flow rate (PEFR) measurements to assess the patient's asthma. The nurse entered the patient's chronic disease medications into the EMR but the physician did not electronically sign the order and it's unclear when or whether the patient received medications because no MARs have been scanned into the EMR to show what medication the patient is receiving.

On 2/11/14, the physician saw the patient noting that he has blurry vision, his blood sugar was greater than 500 the previous night, and his diabetes was difficult to control at his previous facility. The patient's blood pressure was not at goal (BP=141/91 mmHg). The physician ordered labs, referral for podiatry and eye examination, and enrollment in the chronic disease program. He planned to begin lantus and regular insulin per sliding scale but apparently did not authorize the medication orders in the EMR until 2/18/14. The physician did not document what sliding scale insulin doses that the patient was supposed to receive according to his blood sugar values.[15]

Over the following weeks the patient's blood sugars were in the high 200 to 400 range but nurses did not document taking any action, including notifying the physician to obtain orders for sliding scale insulin when it appears none were authorized. Even when the physician rewrote orders on 2/18/14 for Lantus and regular insulin on a sliding scale, nurses did not consistently document doses of administered to the patient. As a result, the EMR shows that when the patient's blood sugar was extremely elevated, nurses did not administer insulin to the patient.

[13] An optician is a technical practitioner who designs, fits and dispenses corrective lens, but does not diagnose and treat eye diseases.
[14] Patient #6.
[15] The term "sliding scale" refers to the progressive increase in the pre-meal or night time insulin dose, based upon predefined blood glucose ranges. For example, if the blood glucose is 150-199, give 1 unit of regular insulin; if the blood glucose is 200-249 give 2 units of regular insulin, etc.

For example, I found the following entries in the EMR for which there was no documentation that the nurse administered scheduled or sliding scale insulin:

3/4/14 am BS=402.

3/9/14 am BS=457.

4/13/14 am BS=299

4/17/14 am BS=237

4/19/14 pm BS=503

4/23/14 am BS=330

Thus, the record shows that the patient did not receive ordered medical care his poorly controlled diabetes.

On 2/24/14 labs confirmed that the patient's diabetes was poorly controlled (hemoglobin A1C=12.5%, goal<7.0%). The physician reviewed the report on 3/3/14 and added another type of insulin to the patient's regimen but did not see the patient to discuss the lab results and reason for changing his treatment. As of 5/15/14 a provider has not seen this patient for management of his diabetes, hypertension and asthma. I find no documentation that the patient has received the physician-ordered eye and foot examinations. Based on the patient's current medication profile, the oral medications he was taking at CMCF (glucophage and glipizide) were not continued at EMCF.

Assessment: This record shows that at each step of the process, the patient's medical care is inadequate. He was not screened timely upon arrival, his medications were not renewed timely, nurses do not consistently document administration of scheduled or sliding scale insulin doses in the medical record; medication orders do not include sliding scale insulin orders so there is no documentation of what insulin dose the patient is supposed to receive; and in many cases there is no documentation of what insulin dose, if any, that he actually receives. This is extremely dangerous for the patient. In addition, the physician does not clinically evaluate the patient in accordance with his disease control and makes changes to the patient's treatment regimen without discussing the changes with the patient. It appears that the patient has not had medication continuity for his oral diabetes medications, but there are no medication administration records in the EMR to confirm this. The patient has not received ordered eye and foot examinations. The patient also should be considered for a statin drug in accordance with new cholesterol guidelines.

In another case, a patient has not received appropriate and timely care for rheumatoid arthritis and has not been diagnosed with hypertension that he has had for at least 18 months. This is a 65 year-old transferred to EMCF on 2/6/13.[16] His medical history includes rheumatoid arthritis, delusional disorder and adjustment disorder.

[16] Patient #9.

On 5/8/13 a NP saw the patient for multiple complaints including swelling of his hand joints and a black mole on his thigh. The NP did not take a history of his joint complaints but referred the patient to dermatology for removal of the mole. On 6/24/13 the mole was removed but I find no documentation that the pathology report was received, reviewed and addressed with the patient.

On 10/19/13 the NP saw the patient again for having "staph all over his body" and swollen joints. The NP noted swelling and deformity to the patient's hands, wrists, and ankle. His blood pressure was elevated (BP=145/67 mmHg). The NP ordered labs for rheumatoid arthritis that were not completed for a month. These tests were consistent with rheumatoid arthritis and signed by the nurse practitioner (11/24/13) and physician (11/25/13) but neither provider scheduled the patient for follow-up.

Four months later, on 2/13/14 the physician saw the patient for a reported staph infection and recent elevated rheumatoid level. He noted the patient had multiple bilateral joint deformities including ulnar deviation of the fingers. The patient's blood pressure was elevated (BP=157/85 mmHg). The physician's diagnosis was rheumatoid arthritis without active synovitis and eczema. His plan was nonsteroidal anti-inflammatory medications (NSAIDs) as needed and cream/lotion for his skin. The provider did not address the patient's elevated blood pressure. The provider did not request follow-up.

On 4/16/14 the physician saw the patient for an erythematous and swollen left elbow as well as a boil on his right chest wall. He noted the patient has a long history of bacterial skin infections and that the patient had a large, edematous and erythematous right olecranon bursa[17] and a small draining ulcer on right chest wall. The physician drained the patient's right elbow and sent the fluid for culture. He ordered Bactrim DS twice daily for 14 days, Motrin for pain and inflammation, and that staff wrap the elbow with sterile gauze daily. On 4/22/14 the physician again drained the patient's elbow and planned to refer him to a rheumatologist.

Review of the patient's electronic medical record flow sheet shows that he has hypertension for over 18 months for which he had not been diagnosed or treated. His blood pressures have been as follows:

10/19/12	BP=167/88 mmHg
10/24/12	BP=163/85 mmHg
2/27/13	BP=160/87 mmHg
8/19/13	BP=150/98 mmHg
2/13/14	BP=157/85 mmHg

Assessment: This patient did not receive timely evaluation, diagnosis and treatment for his rheumatoid arthritis and he has undiagnosed and untreated hypertension that places him at risk for heart attack, stroke and kidney disease. The patient did not have any follow-up for the black mole on this thigh and I find a no pathology report in the record.

[17] The bursae are sacs located throughout the body that act as cushions between bone and soft tissues. The olecranon bursa is located at the elbow.

Inadequate Asthma Treatment

A 40 year-old man with severe asthma, TB infection and weight loss arrived at EMCF on 12/31/13.[18] He was sent to the emergency department and/or was hospitalized for poorly controlled asthma 7 times in the next five weeks, including ICU admission for respiratory failure.[19] In addition, From March 2013 to April 2014 the patient had documented weight loss of 45 lbs (195 lbs.→150 lbs.). EMCF providers have not noted or addressed his weight loss.

On 12/31/13 when the patient transferred to EMCF, a nurse entered medication orders into the electronic medical record (EMR) but these orders were not cosigned by the physician until 1/6/14. The next day the patient developed respiratory distress and was sent to the hospital. The patient told the admitting physician that he had not received his medications following his arrival to EMCF and also had weight loss.[20] The following day the patient was discharged from the hospital back to EMCF with antibiotic orders; however the EMCF physician did not review and address the medication order until 1/6/14. By this time, the patient had been readmitted to the hospital for a second time.

At the time of our site visit, none of the patient's MARs had been scanned into the EMR, however following our onsite review, the patient's February 2014 MAR showed that he did not receive his asthma medication (Singulair) from 2/1 to 2/5/14. On 2/6/14 he presented to medical in respiratory distress and was sent to the hospital where he was admitted to the intensive care unit.

Each time the patient discharged back to the facility, he was placed in the infirmary for medical observation. However, the physician did not formally admit the patient to the infirmary and write admission orders for the monitoring that should be provided while he was in the infirmary, such as vital signs and peak expiratory flow rates.[21] The physician also did not include orders for notifying the physician if the patient's condition was deteriorating (e.g., Temperature above 101^0F, PEFR below 200, and oxygen saturation below 90%, etc.). The lack of appropriate medical orders contributed to inadequate monitoring by the nurses while the patient was in the infirmary. Moreover, independent of physician orders, nursing assessments were completely inadequate. Nurses did not assess the patient in any meaningful way, and did not recognize that the patient's condition was deteriorating until the patient was in full-blown respiratory distress and had to be sent back to the hospital. [22]

Assessment: This patient has not had adequate treatment of his asthma resulting in multiple hospitalizations. Factors contributing to the patient's poor control include not receiving ordered

[18] Patient #12.
[19] The patient was sent to the emergency department and or hospitalized on 1/1/14, 1/5/14, 1/17/14, 2/6/14, 2/7/14, 3/10/14 and 3/30/14.
[20] The patient's medication administration records from January to April 2014 are not scanned into the medical record at the time of our review. .
[21] Peak expiratory flow rate (PEFR) is a test that measures how quickly patients can expel air. It is measured with a small hand-held device called a peak flow meter and is used in the evaluation of patients with asthma and COPD.
[22] A disconcerting finding is that a mental health counselor documented rounding on the patient and stating that he was without complaints at the same time the patient was hospitalized. This raises questions about the credibility of the medical record.

medications, failure to intensify the patient's baseline treatment by increasing the dose of inhaled steroids, inadequate infirmary care resulting in inadequate assessments of the patient and failure to recognize his deteriorating condition until the patient was in full-blown respiratory distress. Finally, this patient's asthma is of such severity that he should be under the care of a pulmonologist, but this has not been considered. In addition to not receiving adequate treatment for asthma, The EMCF medical providers' have also not medically evaluated the patient for his 45 pound weight loss. Given the patient's history of TB infection, ruling out tuberculosis in paramount not only for the patient, but to prevent transmission of this highly infectious disease to staff and other inmates.

In a second case, a 33 year-old man transferred to EMCF in 2011.[23] At the time of my review, his medical history included severe bipolar disorder, hypertension, asthma with hospitalization and intubation, pulmonary embolus in August 2003, pulmonary aspergillosis[24] and gastrointestinal bleeding. While at EMCF he was hospitalized 3 times for asthma from January 2013 to June 2013, but his medication administration records show that the patient did not receive ordered asthma medications. Health care staff documented that the patient was a "No Show" and noncompliant with his medications. When he was seen at chronic disease clinics and urgently, providers and nurses did not adequately assess the patient by asking about the frequency of asthma symptoms, including nighttime awakening, frequency of inhaler use, among others. The providers did not collect objective data to assess disease control such as the patient's baseline peak expiratory flow rates (PEFRs) either at chronic disease visits; and before and after routine and/or urgent nebulizer treatments. Instead, staff used oxygen saturation to assess the patient's asthma. This is problematic because by the time a patient's oxygen saturation drops below normal (<95%), the patient is in severe respiratory distress, whereas PEFRs measure the degree of airflow obstruction before decompensation occurs. Health care staff did not provide adequate treatment and monitoring when the patient was in respiratory distress. On more than one occasion the provider ordered that the patient be placed in the infirmary for observation, but did not order appropriate clinical monitoring (e.g., vital signs, PEFRs) in accordance with the severity of the patient's condition. Nor did the physician instruct the nurses when to notify him of changes in the patient's condition. This resulted in delays in sending the patient to the hospital. In addition, upon the patient's return from the hospital, providers did not see him in a timely manner, if at all. Neither did providers see this patient for chronic disease management more frequently and intensify his asthma regimen when it was apparent that his condition was poorly controlled.[25] Thus, the primary means by which this patient received medical treatment was to present to medical with an urgent condition. This places the patient at increased risk of preventable morbidity and mortality. It is no wonder that the patient requested a transfer so that he could get adequate treatment.

In addition, this patient transferred to CMCF in June 2013 and transferred back to EMCF in April 2014. While at CMCF he was hospitalized 5 times, twice in respiratory failure requiring intubation. During these admissions he was diagnosed with pulmonary embolus and aspergillosis. In February 2014 the hospital physicians attributed his deterioration to lack of

[23] Patient #5.
[24] Aspergillosis is a disease caused by a fungal infection.
[25] The patient is on a low dose of inhaled steroid, which could be increased in accordance with asthma guidelines and FDA medication labeling instructions.

medication continuity despite personal communication with staff at CMCF. When he transferred back to EMCF in April 2014, neither the physician or nurse practitioner documented an awareness of the patient's medical history while he was at CMCF, the importance of ensuring that he receives his medications, or that the patient requires close monitoring due to the severity of his disease.

A second condition for which the patient is not receiving adequate treatment is right eye blurriness and pain. Review of the health record shows that he lost his vision due to chronic retinal detachment in 2009. Following left eye trauma in 2011 he experienced increased left intraocular pressure that caused eye pain for which he was treated with glaucoma medications. In January 2013 when the patient was hospitalized for asthma, hospital physicians discharged the patient on glaucoma medications that were not renewed at EMCF. In March 2013 the EMCF physician documented that the patient had left eye blindness due to unknown reasons. The physician did not perform an adequate evaluation or establish a medical diagnosis. Instead he deferred to the "optometrist" but did not monitor the patient to determine if the evaluation took place or what the results were.

Assessment: This patient has not received timely and appropriate care of the patient's asthma, and the physician and nurse practitioner appear to be unaware of the patient's other serious pulmonary diagnoses. Lack of medication continuity and inadequate asthma evaluations and treatment are contributing factors to hospitalizations. The patient has also not received timely evaluation of his right eye. Since the patient has lost sight in his left eye, it is even more critical that he receive timely ophthalmological evaluation and treatment.

Inadequate Care of Patients with HIV Infection

This 28 year old man transferred to EMCF on 8/1/11. His medical history includes HIV infection, latent TB infection, schizophrenia, and impulse control disorder. The patient is housed in Unit 6.

Assessment: This patient is receiving routine monitoring for his HIV infection and his disease is well-controlled. However, there are problems regarding his care. First the medical history information appears at the top of each chronic disease visit is either unclear or not contemporaneously accurate. For example, the medical history states that only the right lung functions well, but this has not been further explored or clarified. In addition, the medical history indicates that the patient has shingles with an open wound on his right side. This is old historical information and not current. This may be a provider documentation issue if the provider copies and pastes this clinical information into the note at each chronic disease visit; or it may be a medical records issue if the EMR automatically populates the note with this information. In either case, the provider should document whether each problem mentioned in the medical history is a current problem. This is not occurring.

The nurse practitioner does not perform an appropriate HIV or TB review of systems. For example, at the 4/4/14 visit the patient complained of weight loss that the NP did not evaluate. This is clinically significant because the patient has a history of TB exposure and documented 24 lbs. weight loss since July 2013 (180 lbs.→156 lbs).

The NP did not evaluate new symptoms such as when the patient complained of his mouth feeling "locked-up" and having an open wound. The NP should have evaluated the patient for tetanus and oral infections. The NP does not evaluate medication adherence or document labs values in her notes and comment on trends (improving, stable, or worsening). The patient has not received all HIV recommended care such as a lipid profile and immunizations.

Another issue is that the Problem List notes that the patient is tuberculin skin test positive but according to a mental health counselor note the patient was exposed to a TB case but did not test positive. Therefore the patient should be tested annually for TB infection but has not been tested since 2010. The patient should be evaluated for TB now because of weight loss.

Finally, the nursing evaluation for the patient with chest pain was inadequate as the nurse did not perform any meaningful assessment or address the patient's abnormally low pulse. The physician initiated blood pressure medication without discussing it with the patient. Providers should not initiate medications without meeting with the patient to discuss the reasons for the medication, frequency of dosing, side effects and to answer any patient questions.

In another case, the patient has received routine HIV care but one of his HIV medications that contains two antiretroviral drugs was not renewed and he is now receiving only two of four prescribed HIV medications. This is a 55 year old man who transferred to EMCF in late 2010 or early 2011.[26] His medical history includes paranoid schizophrenia, HIV infection and hip pain. His current medications are boosted Kaletra, Haldol Decanoate, benztropine, artane, levetiracetam, and naproxen.

Prior to his transfer to EMCF the patient was taking Truvada, Reyataz and Norvir. Apparently his medication adherence has been good and his HIV disease has been generally well-controlled. In August 2009 his weight was 171.

At the time of his transfer to EMCF his weight was 141 pounds and by 5/11/2011 his weight is 135 lbs. Medical staff did not address his weight loss.

In August 2011 the patient was withdrawn and did not come to treatment team and was given an RVR. On 10/15/11 the patient was in the infirmary with mitts on. The psychologist saw him for daily rounds. The patient who asked why the mitts could not come off. The psychologist reported that the Warden ordered that the patient had to have the mitts on. It was decided by the head staff and there is nothing the psychologist could do to change that decision.

On 11/27/2012 an LPN saw the patient for a "chronic disease" visit. The patient's weight was 140 lbs. and his vital signs were normal. No other assessment was performed.

On 3/8/13 a nurse practitioner saw the patient but documented that she was unable to obtain information from the patient because he was too drowsy. Nevertheless, the NP documented a complete physical examination. His weight was 143 pounds. The NP did not reference the patient's HIV labs. His Dilantin level was subtherapeutic and her plan is to make sure he gets his snack and Dilantin.

[26] Patient #18.

On 8/6/13 the physician documented that the patient had HIV and was on treatment. He did not perform an assessment of the patient but planned to refer him to the HIV clinic. On 8/13/13 the only HIV medication noted on his list of current medications is Kaletra.

On 10/13/13 an NP saw him for HIV care. The NP performed no review of systems and from the note it appears she did not even speak with the patient. Labs were not referenced. Exam was documented as being completely normal including neurological exam. The NP made no reference to recent head trauma and subdural hematoma. A follow-up appointment was requested

On 10/22/13 the ID provider saw the patient noting that he was familiar with him having seen him during his hospitalization for seizure. He noted that the patient had a history of seizure and was found to have a subdural hematoma after being beaten up at the prison. Labs showed his HIV disease was well-controlled. He indicated that he needed follow-up with neurosurgery and to return in 3 months.

On 12/23/13 his CD4 count was 325 and viral load was undetectable. His lipids were elevated (LDL =134). The increased LDL was not addressed.

On 3/12/14 his medications are Truvada and Kaletra. On 3/24/14 his cholesterol was higher (LDL=152) and HIV labs showed he was well-controlled (CD4=341 and viral load <20).

On 3/28/14 the patient was found lying on the floor with a laceration to his head. He was incontinent of bladder. Because of a possible seizure he was sent out to the hospital. There were no acute findings on CT. The staff placed sutures and then returned him to EMCF. I find no documentation that the new physician saw the patient upon his return from the hospital.

On 3/31/14 the physician wrote an order to remove the sutures on 4/2/14, but they were not removed for two more weeks (4/15/14).

On 4/7/14 an RN documented a return from off-site note from a (?) ID specialist but she does not appear to have seen the patient. She noted that the patient was to have follow-up on 7/17/14.

On 5/9/14 a NP saw him for chronic disease follow-up. There is no documentation of any discussion with the patient. Vital signs were taken but no temperature. No scale present to weigh the patient. No labs, assessment of disease control, or documentation of what medications the patient was taking were ordered or performed. No did the NP note the patient's elevated LDL.

As of 4/19/14 the only HIV medication the patient is taking is Reyataz, and Truvada appears to have fallen off the medication list, but I found no MARs in the record to show what medications the patient is receiving.

Assessment: HIV treatment is unacceptably deficient because the nurse practitioners who see the patient do not perform an HIV review of systems, document any discussion with the patient, note current labs, or document the patient's disease control. Fortunately, an ID specialist saw the patient in October 2013 and January 2014 and his HIV disease is well-controlled on the current regimen. However, in March 2014 his Truvada, a combination of two HIV medications, does not appear to have been renewed and he is now taking only a boosted protease inhibitor. Current MARs are not scanned into the record, so I cannot confirm if Truvada has been actually

discontinued with resulting effects on his viral suppression. If left off Truvada this will quickly lead to viral resistance and deterioration of his HIV disease.

Inadequate Care of Patients with Serious Eye Disease

Patients have a right to a medical professional who can diagnose and treat their serious medical conditions. For patients with diseases that involve the eyes, providers trained and licensed to diagnose and treat eye diseases include optometrists and ophthalmologists. HALLC has contracted with an optician to perform optometry services. The optician performs examinations that he is not qualified to perform.

I reviewed a Sick Call Log that contained eye complaints and requests for glasses dated from 11/12/12 to 11/7/13.[27] The log shows the date the request was received, inmate name and ID, type of complaint, date scheduled and date seen. The log shows that the majority of entries have no date scheduled and no date seen, even for patients complaining of inability to see and blurred vision, which may represent a change in visual acuity or a more serious eye disease such as glaucoma. This suggests that the tracking system to ensure that the optometry appointments are conducted timely is not being maintained. This evidence of inadequate services was supported by my record review in which I found that patients with serious eye disease do not have timely access to a qualified medical professional and are not receiving adequate treatment and medical follow-up.

One such example involves a 50 year-old man transferred to EMCF in 2012 and transferred to CMCF in October 2013. His medical history included hypertension, hyperlipidemia, focal retinitis and retinochoroiditis[28] and bipolar disorder or antisocial personality.

On 5/30/13, the optician performed a complete optometry examination noting intraocular pressure and retinal findings in both eyes.[29] He described the disc, margins, macula, vessels, background and vitreous for both eyes as being normal. He diagnosed him with dry eye and a cataract and wrote a prescription for glasses.

On 8/8/13 Dr. McMillan saw the patient for focal retinitis and retinochoroiditis, left eye decreased visual acuity and dry eye syndrome. Dr. McMillan did not describe the retina for the right eye because it could not be visualized due to a cataract. In the left eye there was retinal scarring inferiorly. In his note he referred to the optician as "Dr. Snell" who diagnosed his cataract. Dr. McMillan recommended cataract extraction to improve visual function. The patient has not had further follow-up for removal of his cataract at EMCF. He transferred to CMCF in October 2013 and on 3/26/14 underwent removal of a right eye cataract

Assessment: The optician documented a completely normal optometric examination of both eyes when the patient had a right eye cataract that precluded visualization of the retina. There

[27] HALLC Eye 2.134.
[28] Retinochoroiditis is a disease of the retina.
[29] This report was not scanned into the electronic medical records that were forwarded to me.

was no documentation in the record while the patient was at EMCF that Dr. McMillan's recommendations were addressed.

In other cases, I found that patients with glaucoma and other eye diseases did not receive ordered medications. Earlier in this report, I described a patient who was blind in his left eye due to a chronic detached retina for which glaucoma medications were prescribed but not received; and who was having pain and blurriness in his right eye and had not had adequate evaluation and treatment by an optometrist or ophthalmologist. [30]

In another example, a 53 year-old man transferred to EMCF on 12/27/11.[31] His medical history included diabetes. The patient also had glaucoma but this diagnosis was not documented on the problem list. We interviewed the patient who reported that he had glaucoma but was not receiving medication for it. I reviewed the record and noted there is there was not an active medication order for glaucoma medications.

His record shows that on 3/15/12 the optician saw the patient who reported that "things look dark". The optician diagnosed the patient with cataracts and recommended referral to UMC for cataract and diabetic consultation. On 4/3/12 the optician saw the patient again who reported he was "going blind". The patient had significantly decreased visual acuity and his intraocular pressure was borderline elevated. The optician noted the patient had nonproliferative diabetic retinopathy and was a [glaucoma suspect (POAG) suspect] suspected to have glaucoma?. The plan was to refer to the patient to the ophthalmologist ASAP in less than a month. The optician recommended Alphagan eye drops (for glaucoma), glucose and blood pressure control.[32]

On 4/24/12 the ophthalmologist saw the patient for diabetic retinopathy and treated the right eye with laser therapy and planned to schedule the patient for treatment of his left eye. I do not find documentation that the patient returned to him for treatment of the left eye. On 10/18/12 the ophthalmologist saw the patient for diabetic retinopathy follow-up. He noted that the patient "declined presence of any drops since left here last, seen any eye doctor." He noted that the patient had stable macular diabetic edema and severe nonproliferative diabetic retinopathy, bilateral cataracts that did not require surgery and primary open angle glaucoma for which he recommended Xalatan drops at bedtime in both eyes. The ophthalmologist recommended follow-up in four months, but that did not occur. Seven months later, on 5/21/13 the patient was sent to another ophthalmologist who wrote only a brief note that the patient's vision was less than 20/200 and he unable to improve vision. He recommended continuing eye drops for glaucoma. The patients' diabetes remained poorly controlled. On 9/13/13 the optician saw the patient and performed what appears to be a limited exam, not measuring visual acuity or intraocular pressure. The patient has not been seen by an ophthalmologist since.

Assessment: This patient has diabetic retinopathy, macular edema, glaucoma, and cataracts but is not receiving timely and appropriate care for these conditions. Most urgently, the patient is

[30] Patient #5.
[31] Patient #8.
[32] There is no clear documentation that the optician spoke with or obtained an order from a provider licensed to prescribe medications for this medication.

not receiving glaucoma medication. I am concerned that the optician is performing examinations outside his scope of practice as an optician.

Specialty Services

At EMCF patients do not have timely access to specialty services and follow-up of specialist recommendations resulting in a risk or actual harm to the patient. I found lack of timely access to be the case in eleven of eighteen records I performed for this review.

This includes:

- A 25 year old patient with metastatic testicular cancer who did not have timely access to a urologist following an abnormal ultrasound showing a right testicular mass.[33]
- A 31 year old patient with a brain tumor who has not received timely CT scan and referral to a neurosurgeon.[34]
- A 64 year old patient with undiagnosed and untreated diabetes who has reported losing his vision and has not received an optometry evaluation and referral to a retinal specialist.[35]
- A 33 year old patient with left eye blindness present with blurriness and pain in his right eye who has not received ophthalmological evaluation.[36]
- A 36 year old patient diagnosed with early glaucoma in May 2012 who had not received glaucoma medications and as of April 2014 has had no further follow-up.[37]
- A 53 year old poorly controlled diabetic with diabetic retinopathy and glaucoma who has not received ophthalmological follow-up or glaucoma medications.[38]
- A 47 year old poorly controlled diabetic who has not received optometry and podiatry examinations.[39]
- A 50 year old patient with retinochoroiditis and right eye cataract for whom the retinal specialist recommendation removal. The patient had no further follow-up at EMCF.[40]
- A 65 year old patient with rheumatoid arthritis who presented with symptoms in May 203 and was diagnosed in November 2013 whose request for rheumatology referral was not made until April 2014.[41]
- A 55 year old patient with subdural hematoma following correctional officer use of force who did not received recommended MRI and neurology follow-up.[42]
- A 70 year old patient with prostate cancer who did not receive urology follow-up and for whom the EMCF providers are unaware of August 2013 bone scan and oncology

[33] Patient#17.
[34] Patient #2.
[35] Patient #15.
[36] Patient #5.
[37] Patient #13.
[38] Patient #8.
[39] Patient #6.
[40] Patient #14.
[41] Patient #9.
[42] Patient #18.

radiation recommendations. The patient also did not receive a CT scan for blackout spells. This patient is described below.[43]

This 70 year-old man arrived at EMCF on 2/13/14. He had previously been housed at EMCF but transferred to a county facility in April 2013. His medical conditions included hypertension, CAD with stents in 2008, atrial fibrillation, COPD, degenerative joint disease (DJD), prostate cancer since 2006 and urinary tract infection.

Prior to arrival at EMCF the patient was under the care of a urologist for prostate cancer. While he was at another correctional facility, on 8/13/13 the patient had a bone scan for generalized bone pain and history of prostate cancer that showed increased activity in the cervical, lumbar spine, wrists and knees that was associated with DJD [explain] although metastatic disease could not be completely ruled out. On 12/19/13 the patient had an oncology radiation consultation at Gulfport Memorial Hospital. The oncologist discussed Lupron therapy with the patient who declined treatment at that time but was told to let him know if he changed his mind. On 1/22/14 a health transfer summary from Harrison County Detention Center noted that the patient had a radiation oncology referral pending at Gulfport Memorial Hospital although it had actually taken place in December.

On 2/13/14 the patient transferred to EMCF and medical and mental health screening were performed upon arrival.

On 2/19/14 the physician saw the patient for a history and physical. The physician did not address the patient's history of prostate cancer and recent oncology consultation. On 2/20/14 labs were essentially within normal limits except his PSA was significantly elevated, and on 2/21/14 the physician referred the patient to urology. On 3/18/14 a urologist saw the patient and noted that he had previously been lost to follow-up. He had complaints of urinary frequency, nocturia, urgency, and incomplete bladder emptying, and was recently started back on Flomax. Urinalysis showed blood and nitrites. Bladder scan post voiding residual (PVR) showed 570 cc of urine. He recommended increasing Flomax to twice daily. The urologist planned to get records of Dr. Mathews, and have the patient return in 2 weeks to check PVR (post void urine residual). Upon return to EMCF an RN noted the urologist's recommendations, including follow-up in two weeks. The patient's flomax was increased the same day.

On 3/11/14 the physician saw the patient for blackout spells. He ordered a CT scan with and without contrast. As of 5/15/14 the procedure had not been completed and the patient had no further follow-up for this condition.

On 3/20/14 the physician reviewed the report but did not see the patient. Requested follow-up with the urologist was due on 4/1/14 but as of 5/15/14 had not taken place.

On 3/21/14 an NP saw the patient for chronic disease management. The NP referenced the patient's prostate cancer and that he had dysuria, but did not ask about obstructive urinary tract symptoms or note the urology appointment that occurred 3 days earlier. The NP made no reference on the status of the patient's prostate cancer treatment or follow-up.

[43] Patient #11.

Assessment: This patient did not receive timely and appropriate continuity of care for his prostate cancer and black-out spells. We reported this case to the Health Services Administrator prior to leaving the institution. On 6/10/14 the patient died, reportedly a possible suicide.

Pharmacy Services and Medication Administration

I evaluated pharmacy and medication services by interviewing staff, and reviewing applicable policies, reviewing medical records including medication administration records, observing nurses administer medications in general population and restricted housing units. Following this review I have determined that medication policies and procedures are inadequate, nurses do not follow nursing practice standards when administering medications, and health records do not show that patients receive medications for serious medical conditions.

Pharmacy Services

HALLC policy and procedure on Pharmaceutical Operations is dated October 1, 2009. The policy is not site-specific and does not provide sufficient operational detail regarding pharmacy services. The policy states that medication services will be addressed in the following policies and procedures:

- Medication Administration
- Prescribing Authority and Stop Dates
- Transcription of Medical Orders
- Medication Administration Record
- Medication Errors
- Psychotropic Medications
- Monitoring Psychotropic Medications

However, HALLC policies only include the first medication administration policy and not the other six policies. Nor do the HALLC policies reference other applicable policies, such as MDOC, to be adhered to in the absence of HALLC policies.

The Health Services Administrator reported that that pharmacy services are provided by IHS an off-site pharmacy service. IHS packages medications in single containers that may include multiple medications for the nurse to administer at a medication line. Each container is labeled with the names of the medications, the color and shape of the medication, and the medication instructions.

To initiate a medication order, a provider enters a medication into the electronic medical record, electronically signs the order, and staff prints and faxes the order to the pharmacy. The medications are usually delivered the next day. In some instances, such as at intrasystem transfer or when the patient returns from the hospital, a nurse enters the patient's medication orders into the EMR and the provider is supposed to review and electronically sign the order. However we found problems with documentation of medication orders in the medical record. In some cases, the provider does not electronically sign his own order and the pharmacy does not fill the

prescription. In other cases, a nurse enters the order but the provider does not sign the order in a timely manner, if at all. These issues resulted in medications not being received in a timely manner following intrasystem transfer or hospitalizations, and contributed to patient's poorly-controlled chronic diseases and re-hospitalizations of patients.[44]

Although I observed variances in how nurses and providers entered and signed medication orders in multiple records, I was not able to assess whether or not patients received medications timely if at all because medication administration records (MARs) had not been scanned into electronic health records for six month, since October 2013. Thus it was not possible to assess medication timeliness or continuity because of the incomplete health record.

This is not simply a medical records issue; it negatively impacts care. The failure to scan MARs into the medical record in a timely manner results in an incomplete health record that can result in harm to patients. It does not permit providers to know whether or not the patient is receiving ordered medical treatment. It does not permit staff to assess whether the patient is refusing medications or whether there are other reasons that the patient is not receiving medication such as failure to renew a chronic disease medication, or the medication not being available from the pharmacy.

It is critical to know whether patients are taking their prescribed medications so the treatment plan can be adjusted accordingly. For example, if a patient with diabetes or high blood pressure is taking his medication, but the patient's disease is not well-controlled, the provider should adjust medication dosage or add a new medication. However, if the patient is refusing his medication the provider should explore the reasons with the patient, including medication side effects or lack of understanding of the reason for the medication. This is important in any patient setting, but particularly so in a facility treating seriously mentally ill patients, many of whom have serious medical conditions.

I also found that in the record of diabetics, physicians do not write medication specific orders for sliding scale insulin in the patient's record. The term "sliding scale" refers to the progressive increase in the pre-meal or night time insulin dose, based upon predefined blood glucose ranges. For example, an order may state that, if the blood glucose is 150-199, give 1 unit of regular insulin; if the blood glucose is 200-249 give 2 units of regular insulin, etc. As noted earlier in this report, physicians do not document in each patient record the scale of insulin doses to be given to the patient based upon blood glucose ranges. Apparently, insulin sliding scales are considered a standing order. This practice is not in compliance with NCCHC standards.

Moreover, nurses do not document administration of scheduled and sliding scale insulin with corresponding dosages onto to MARs. Instead, the health services administrator informed us that nurses are to document administration of schedule and sliding scale insulin in the same electronic notes that nurses document blood sugar checks, which is usually done twice daily. However, I found cases nurses in which nursing documentation of scheduled or sliding scale insulin was deficient, or not documented at all, even when glucose levels are extremely abnormal.[45] For example, nurses documented "Humulin insulin per s/s protocol". Therefore, not only is there no

[44] Patients #5, #6 and #12.
[45] Patients #6, #13 and #20.

medication order in the record for sliding scale insulin, nurses are not documenting how much insulin they have given the patient. The lack of documentation of insulin administration means that patients have not received the medical care that was ordered.

Another serious problem is patients with glaucoma not receiving their medications to reduce intraocular pressure that can lead to vision loss Review of one record showed a multitude of contributing factors including the ophthalmologists recommendations not being ordered by EMCF physician, failure of the nurse or pharmacy to transcribe the medication order onto the MAR, and lapses of medication orders. Another glaring issue is nurses' failing to review the patient's MAR and note that the patient has not received the ordered glaucoma medication. The following case is a shocking example of this.

This is a 28 year old man who transferred to EMCF on 8/25/09. His medical history includes and glaucoma from age 9. On 9/11/09 an optician/optometrist saw the patient. He noted that the patient was taking intraocular pressure drops (for glaucoma) and started the patient on Timolol that he received timely in September and October of 2009.

Over the following months the patient did not receive his glaucoma medication for the following months: 11/2009, 12/2009, 1/2010, 2/2010, 3/2010, 7/2010, 8/2010, 9/2010, 11/2010, 1/2011, 3/2011.

In April 2011 the optometrist added another medication because the patient's glaucoma was not - controlled and his vision was worsening. He planned to see him in a month. However the medication was not ordered.

The pattern of missed medications continued and the patient did not receive his glaucoma medications for the following months: 06/2011, 07/2011, 08/2011 0/9/2011, 10/2011.

On 11/11/11 the optometrist saw the patient again and believed that he was taking Xalatan and Timolol his glaucoma was still uncontrolled. He noted that he last saw the patient on 4/1/11. He added a third medication, Combigan to Xalatan and Timolol and referred him to an ophthalmologist. He requests to see him in one month.

On 2/2/12 the patient was seen by an ophthalmologist who noted advanced glaucoma in both eyes and elevated intraocular pressures despite being on Xalatan. The medication record from the prison indicates that the patient is only getting one IOP drug but the patient claimed he was getting three drugs. The consultant recommended aggressive lowering of intraocular pressures. Given his advanced glaucoma he should see a glaucoma specialist. He recommended 3 IOP medications (Xalatan, Combigan and Trusopt). Return to clinic in 3 weeks if a glaucoma specialist could not be found). The patient was not referred to a glaucoma specialist or to the ophthalmologist.

His February 2012 MAR showed that he received only the Lantanoprost per order of Dr. Faulks and not Trusopt or Combigan.

The pattern of the patient not receiving his glaucoma medication continued until June 2013 when he received all three medications. By this time, vision in his right eye had significantly deteriorated. He was transferred from EMCF in July 2013.

Assessment: This case is shocking for a number of reasons. The physician did not monitor the patient to ensure that he received timely ophthalmological care, and did not ensure that the specialists recommendations were implemented once received. In addition, it appears that the patient receiving the glaucoma medications from the pharmacy was dependent on the medication nurses ordering the medication from the pharmacy. The patient was also receiving psychotropic medication on a daily basis. Therefore, medication nurses saw the patient day after day after day, seeing the order for KOP glaucoma medication on the MAR, and each month took no action to ensure that the patient received medications for a serious medical condition. This is the epitome of deliberate indifference. Finally, it was only the month before the patient left EMCF that the medication was changed from KOP to nurse administered, a change that could have easily been made in the preceding years if anyone had cared to notice.

Medication Administration Process

Medication administration takes place twice daily, at 0900 and 2100, although there are some medications given at 1300 when ordered three times daily. In general population a nurse takes a medication cart to the housing units. Inmates come to a window to receive their medications. In segregation nurses administer medications cell to cell. A correctional officer is assigned to each nurse. The officer is supposed to provide general security and conduct oral cavity checks.

I observed three nurses administer medications on general population housing units 3 and 4 and found that nurses do not follow standards of nursing practice.

- None of the nurses asked the patient to state his name when he came to the window.
- Nurses asked each inmate to present their identification (ID) badge, however, when inmates presented their ID badge none of the nurses consistently looked at the name on the badge to ensure that it was the correct patient. One nurse simply tapped the ID badge when the inmate presented it.
- All nurses had the medication administration record book with them at the time they administered medications. Two nurses did not document on the MAR at the time they administered the medication to the patient. The third nurse checked the MAR and compared it to the medication package and documented administration of the medication on the MAR immediately before she gave the medication to the patient.
- Inmates are provided a small soufflé cup with water that in some cases likely does not provide enough water to swallow pills.
- Neither the nurse nor correctional officers consistently performed oral cavity checks to ensure that the inmate swallowed his medication.

I also observed nurses administer medications in segregation units 5A and 5D. These nurses also did not adhere to standards of nursing practice when administering medications.

- Nurses did not ask inmates to verbally identify themselves when they came to the door. There is no identifying information on the inmates' cell.
- Nurses requested identification badges from inmates when the presented to the door, but did not consistently look at the name on the badge to ensure it was the correct inmate.
- Some cell doors had a fine mesh metal grate covering the window so that it was not possible for the nurse to read the ID badge.
- Nurses administered medications by passing the medication package through a slot in the cell door.
- The nurses made no attempt to observe the inmate swallow the medication by requesting that the officer open the door to perform oral cavity checks, or even to look through the cell door window.
- Nurses did not document administration of medications at the time they administered the medications to the patient.

See Skipworth's report. We found piles of piles in many cells.
By this medication administration process there is virtually no way for nurse to ensure that they have administered the right medication to the right patient and that the patient has taken the medication. In some records, it was later shown that patients did not take their medications.[46]

We interviewed inmates who reported that a nurse asking for an ID badge at the time of medication administration was a new practice. Some inmates reported that it had occurred for the past week and others said several weeks. One inmate reported that he has not had an ID badge for a year and a half and never had problems getting his medication until recently. On the day we observed medication administration, he reported that the nurse would not give it to him.

I spoke to an officer on the unit and asked when nurses started requesting ID badges while administering medications and she reported about 2-3 weeks. I also asked what procedure should be followed for an inmate to obtain a new ID badge. She responded that she did not know the process for obtaining a new ID badge.

Following medication administration, I returned to the medical unit. Later that afternoon I observed 3 nurses documenting on medication administration records (MARs). One medication administration record book had a divider that indicated they were MARs from 5D.

Nurses must ensure that they administer the right medications to the intended patient, at the right dose at the right time, by the correct route. The standard of practice for nursing administration is to positively identify patients at the time of administration using two identifiers, to ensure that the pharmacy-prepared medication has the correct medication and dosage, and to observe the patient taking the medication. Following these steps, the nurse documents administering the medication.

[46] Patient #11.

Medical Observation/Infirmary Care

To evaluate this area, I toured the medical observation/infirmary unit, reviewed an Infirmary Log, and reviewed records of patients placed in medical observation/infirmary.

EMCF staff report that they have a medical observation unit and not an infirmary. However my review showed that physicians place inmates requiring higher level care into the medical observation unit/infirmary. This includes patients with poorly controlled asthma, chest pain, head trauma, facial burns and post-operatively following surgery.[47] *Record review showed that these patients suffered preventable morbidity and mortality due to inadequate policies and procedures, as well as deficient monitoring and treatment by health care staff.*

I reviewed the HALLC policy and procedure regarding Sheltered Housing dated October 1, 2009. This policy is based upon ACA and NCCHC standards regarding health services in prisons. The policy states that:

"Sheltered housing will be provided for inmates who, though not requiring admission to an outside hospital, still require care for an illness, injury or condition or diagnosis that requires medical management."

The categories of sheltered housing include:

- Sheltered Housing-For inmates whose medical conditions restrict their activities and inhibits their access to medical care from their housing area. This care is also reserved for inmates who require a more protective environment but do not require twenty-four hour nursing care:
- Extended Care-For inmates who are terminally ill, have impaired mobility, and/or are in the final stages of a chronic disease
- Medical Observation-For inmates who require short term observation, usually less than 24 hours.

The policy also states that the Medical Director will be responsible for monitoring the care of sheltered housing patients, that nurses will make rounds a minimum of once per shift or more often as required by the patient's needs, conditions and clinical orders and that these rounds will be documented in the medical record; and that significant changes will be reported to the responsible practitioner. Patients will be within sight or sound of a qualified health care professional through visual or auditory requirements.

Although based upon the NCCHC Infirmary Care Standard (P-G-03) the policy is not compliant with the standard. The NCCHC standard requires that a complete inpatient record is kept for each patient and that the record includes:

[47] Medical Admission Infirmary Log. HALLC Adm Log 1-42.

- admitting order that includes the admitting diagnosis, medication, diet, activity restrictions, diagnostic tests required, and frequency of vital sign monitoring and other follow-up;
- complete documentation of care and treatment given;
- the medication administration record; and
- A discharge plan and discharge notes.

At EMCF there are 10 cells in the infirmary that are used for mental health or medical patients. Health care leadership reported that the beds are used primarily for mental health patients on suicide precautions and few beds are used for medical purposes. The cells have no call system for patients to contact staff if they are in distress. Staff reported that correctional officer conduct 30 minute checks. Thus, patients are not within sight or sound of staff at all times as required by NCCHC standards and by HALLC policy.

We observed one cell used for psychiatric observation cell that is not equipped with an in-cell camera. On the day tour there was a patient in this room. The glass of the cell is so obscured that even standing right outside the door it was difficult to see the patient unless he moved. Although used for patients on suicide precautions, the cells are not suicide proof as there are metal bars on the beds from which patients could attempt to hang themselves.

Although leadership reported that the rooms are primarily used for mental health purposes and short term medical observation (i.e. less than 24 hours), my review showed that physicians and nurses place patient's with serious medical conditions, such as poorly controlled asthma and head injuries, in the infirmary for up to a week at a time without formal admission and without accompanying medical orders for activity, diet, vital signs and other clinical monitoring appropriate to the patient's condition; as well as clinical criteria for notifying the physician when the patient's condition is deteriorating.

Medical providers do not perform rounds and document examinations for patients in the infirmary in accordance with the severity of their conditions. In one egregious case described below, a physician placed a patient in a medical observation cell with a head injury following a use of force by correctional officers. The physician did not document any medical evaluation of the patient or perform any neurological assessment during the 10 days the patient was in medical observation or the infirmary.[48] The patient's condition progressively deteriorated until he developed seizures and when sent by ambulance to the hospital was found to have a subdural hematoma from trauma.

The patient is a 55 year old man who transferred to EMCF in late 2010 or early 2011. His medical history includes paranoid schizophrenia, HIV infection and hip pain.

On Thursday 8/29/13 at 1336 a mental health counselor (MHC) saw the patient at the request of security because he refused to remain housed with his cellmate who he said pushed him. The MHC interviewed the cellmate who reported being unaware of any problems and the MHC

[48] This physician is no longer employed at EMCF.

advised the patient to contact his treatment team regarding cellmate issues. He documented that the patient was referred to the NP for evaluation after becoming combative with a lieutenant.

I observed a videotape of the post-altercation care in the medical unit. The videotape shows the officers escorting the patient to the medical section with his hands cuffed behind his back. The patient's face and shirt were bloody. Two nurses approached the patient but did not identify themselves or advise the patient what evaluations or treatment they were about to provide the patient. The nurses began wiping blood from his face and their only direction to him was to "sit still". They did not perform complete vital signs or conduct a neurological assessment.[49] A nurse placed a steri-strip over a laceration above his right eye. The physician was notified and came into the room after the nurses cleaned the patient's face.[50] The physician performed a cursory evaluation, asking the patient to stick out his tongue, whether he had double vision and how many fingers the patient could see. He palpated the patient's scalp and above his eye. He told the officers that he planned to keep the patient in medical observation and that he would see the patient in the morning and determine whether to send him out for an orbital CT. Neither the physicians nor nurses documented an assessment of the patient in the record. The physician did not write any medical orders regarding what the nurses were to observe the patient for and what circumstances were to be reported to the physician (e.g. deterioration in level of consciousness, etc.). The physician did not see the patient in the morning.

On 8/29/13 at 2205 the psychiatric NP assessed the patient following a use of force. The NP documented that the patient was severely agitated with rambling disorganized speech, but also noted that he was alert and oriented. The patient reported auditory hallucinations encouraging him to hurt himself and others. The NP prescribed Haldol 10 mg IM now, to increase Haldol Decanoate to 200 mg IM monthly, Cogentin 2 mg twice daily and Artane 5 mg twice daily. The NP planned to monitor the patient in the medical holding tank for psychiatric observation and follow-up in the morning.

At 2240 an RN documented that the patient would be housed in holding area 541 for the night for psychiatric and medical observation.

On 8/30/13 at 0745 a psychologist saw the patient noting that a "code black" was called yesterday because the inmate was "threatening and spit on an officer". The psychologist described the patient as dirty, drowsy, disoriented, and paranoid with auditory hallucinations and inappropriate affect. He recommended that the patient be placed in medical observation.

On 8/30/13 at 2106 the NP saw the patient who was lying on a mat in the holding room. She described him as catatonic and unable to respond to questions but was rocking on the mattress. The NP's plan was to continue to monitor in medical and may admit to the infirmary when a bed is available.

On 9/1/13 MH staff noted the patient was unkempt and dirty and must be allowed to shower and the room cleaned and disinfected.

[49] Later a nurse measured the patient's blood pressure but took no other vital signs.
[50] The physician came into the room briefly while the nurse's cleaned blood from the patient's face, left and then returned.

On 9/1/13 the physician documented that the patient has purulent drainage coming from his right eye. The patient was "unable to give history due to mental impairment". Lacerations above eye were not draining. The physician's assessment was post-traumatic discharge from right eye and laceration not draining. He ordered Rocephin and Bactrim and noted that he may need to get orbital CT. He ordered that the patient be kept on the unit as inmate is mentally unable to take care of himself and noted an intent to see the patient in the morning. This did not occur.

Over the next 8 days the patient's condition continued to deteriorate. He was left in a "medical observation cell that had no bathroom and he began urinating on the floor and then on himself. Staff noted that he was having difficulty eating foods but he remained in the medical observation room because an infirmary bed was not available. Mental health staff made rounds and documented that the patient was not in distress.

On 9/4/13 NP sees the patient noting that he is still being monitored in a holding cell awaiting a medical bed. He continues urinating on the floor on several occasions and, on others, knocks on the door to go to the bathroom. Today he appears to have decompensated urinating on the floor. The NP admitted the patient to an infirmary bed and ordered 15 minute checks by security. The following day the MHC documents that the patient has symptoms of (tardive) dyskinesia.

On 9/8/13 at 1125 the patient was taken to the shower and assisted by a medical orderly; the patient slid out of the chair and had a ½" laceration on his forehead. The patient was unable to sit up by himself, to ambulate or perform activities of daily living. He was incontinent of bowel and bladder. The nurse did not take vital signs or notify anyone.

On 9/9/13 the patient had three seizures, one witnessed by the NP. The NP notified the physician who ordered the patient sent to the hospital by ambulance. At the hospital a CT scan showed fluid accumulation that was initially thought to be infectious, but later determined to be a subdural hematoma from trauma.[51] On 9/18/13 the patient was discharged back to EMCF with a recommendation for repeat MRI in 3 weeks. The physician did not see the patient upon his return. On 9/26/13 the physician wrote a note stating that the patient was discharged from the hospital in stable condition. He performed no examination. He noted that the patient had an abnormal MRI and was to see Dr. Malloy three days after repeat MRI was completed. I find no documentation that the MRI was performed or that the physician ever saw the patient again.

Assessment: For years this 55 year-old man with paranoid schizophrenia, seizure disorder and HIV infection has had poorly controlled schizophrenia whose treatment consisted primarily of Haldol, Cogentin, Artane and Risperdal. He frequently had symptoms of auditory hallucinations and agitation. On 8/29/13 the record suggests that he was having conflict with his roommate and instead of moving the inmate to another location, this mentally ill patient was advised to take it to the treatment team. Then because the patient "became threatening and spit on an officer" correctional staff used force that resulted in head trauma sufficient to cause subdural hematoma.

[51] On 10/22/13 the Infectious Disease provider saw the patient at the hospital saw him for follow-up for HIV care He noted that the patient had a history of seizure and was found to have a subdural hematoma after being beaten up at the prison.

The videotape shows that correctional staff continued to remain in control of the situation. The physician and nurses did not instruct the officers to uncuff the patient to perform any meaningful examination. They did not document an examination in the EMR or monitor the patient following head trauma. When the patient was placed in medical observation/infirmary, neither medical nor mental health staff adequately monitored and intervened on behalf of the patient, even after he was unable to take care of himself as evidenced by his urinating on himself, inability to feed himself, or to bathe. The lack of appropriate evaluation, treatment and monitoring by the physician is the epitome of indifference and extended after the patient returned from the hospital.

Health Records

MDOC has implemented an electronic medical record (EMR) Centricity throughout the system. Staff is to document all clinical encounters either in the EMR or on paper that is scanned into the EMR in a timely manner so the information is readily available to all staff caring for the patient. Timely scanning of health documents into the correct location decreases the risk of medical errors.

My review showed that EMCF health records are not complete. In some records, providers and nurses either did not document clinical encounters or the information was never scanned or imported into the EMR.[52] In addition, electronic medical record notes and other entries are not filed in chronological order or are in the wrong location, making care difficult to follow.[53] This increases the risk that providers and nurses will miss important clinical information that should be addressed and increases the risk of harm to patients.

Providers do not ensure that the Problem List is complete and updated. As a result, the problem list of diagnoses and the list of medications on the Summary Sheet routinely differ from those listed in progress notes created after the problem list. The Problem List and current medications is different depending on whether a summary form is opened in the record, or individual progress notes. For example, in one patient record reviewed the summary sheet noted that the patient's medications were atenolol and tums, but progress notes that contained his current list of medications had other medications, including metformin, lisinopril and norvasc.[54] This practice defeats the purpose of having a Problem List and the summary sheet.

Many notes in the record are derived from templates (e.g., chronic disease notes) that are designed to ensure that medical providers obtain an adequate past medical history, review of systems, physical examination and document an assessment and plan. However, in practice EMCF providers do not document adequate notes for the following reasons: a section on past medical history either automatically populates the chronic disease note, or providers copy and paste previous notes into the chronic disease note. In some cases, the information documented in the note is not contemporaneously accurate but is not corrected by the provider. This was demonstrated in a record of an HIV patient for whom a provider documented in November 2012

[52] Patient #17 and Patient #18.
[53] These findings were also noted in Marc Stern's MD report.
[54] Patient #1.

that the patient had "shingles and an open wound on the right side". At each subsequent chronic disease visit, this information appeared in the note without being addressed or amended by the provider. Second, under review of systems (ROS), providers are supposed to ask the patient if he is having symptoms of his chronic diseases (e.g., chest pain, shortness of breath, seizures, etc.). Yet documentation showed that providers did not obtain adequate ROS, but simply documented what chronic disease the patient was being evaluated for. Providers did not reference labs in the note, and plans of care appear to be autopopulated or copied and pasted in the note, and did not bear a relationship to the actual plan of care ordered for the patient. In this sense, the design of the note contributes to poor care.

As noted earlier in this report, MARs have not been scanned into the record since October 2013 and it is not possible for health care staff to contemporaneously determine if patients receive their medications.

I also found that providers do not review and address laboratory reports in a timely manner that results in harm to patients. As noted earlier in this report a physician ordered labs for a patient in September 2012 and the labs showed that the patient had undiagnosed and poorly controlled diabetes, but the physician did not review the report or follow-up with the patient and as of our visit had undiagnosed and untreated diabetes.

My review also showed that when patients transfer to EMCF, providers do not adequately review previous medical treatment, including reports of previous hospitalizations[55] and specialty services. Moreover, EMCF providers do not review and follow-up specialist reports in a timely manner, if at all, that has resulted in systemic delays of care for patients with serious medical conditions and harm to patients.[56]

Quality Improvement and Clinical Performance Reviews

To assess this area I reviewed HALLC policy and procedure on Continuous Quality and Improvement Program and reports of EMCF quality improvement activities. My review showed that for all intents and purposes there is virtually no meaningful quality improvement program at EMCF.

HALLC has a policy on Continuous Quality and Improvement Program dated 10/1/2009. It is based upon the NCCHC standards and is comprehensive with respect to the types of activities that should be occurring to identify, and correct problems that may negatively impact the delivery and quality of health care services at EMCF. However, I found no documentation of continuous quality improvement meeting minutes that demonstrated compliance with the policy.

I reviewed one report entitled Quarterly Performance Review of Onsite Inmate Health Services Provided by Health Assurance LLC at Private Institutions. Dated April 1 through June 30, 2013. This report was prepared on behalf of the Mississippi Department of Corrections, Office of Medical Compliance by AdminPros, LLC.

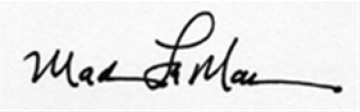
[55] Patient #2.
[56] Patient #11.

This report reflects how well HALLC is meeting compliance measures required by the contract between MDOC and HALLC at the four prisons that HALLC provides health care services. There are 8 compliance standards that HALLC must achieve greater than 90% in order to be compliant with the contract. These include:

- Non-Emergent Health Requests (Sick Call) triaged within 24 hours for which EMCF scored 97.5%
- Sick Call referrals shall be evaluated by a physician or mid-level practitioner within 7 days of the original complaint for which EMCF scored 96.7%
- All inmates will have routine dental prophylaxis no less than every two years, for which EMCF scored 97.3%.
- Inmates referred by a physician or nurse shall be seen by an optometrist within 30 days of referral. Wexford could not produce data for EMCF for reasons not stated.
- A licensed radiologist shall interpret all radiographs the next workday and provide written results within 48 hours after reading. Wexford could not produce data for EMCF for reasons not stated.
- Emergent medications are filled and administered within 24 hours after being prescribed. The EMR is unable to provide reports that can be audited.
- Inmates referred for psychiatric evaluation in all cases except upon intake shall be seen by a psychiatrist within 14 calendar days of referral. The EMR is unable to provide reports that can be audited.
- Inmates who are on psychotropic medications shall be seen by a psychiatrist at least every 90 calendar days, to include telemedicine where appropriate. The EMR is unable to provide reports that can be audited.

Thus, out of 8 compliance measures, EMCF was compliant for 3 out of 4 measures that could be audited. However, based upon my review, I find these data to be not credible. There is no evidence that EMCF has a meaningful quality improvement program,

Respectfully Submitted,



Madeleine LaMarre FNP-BC

June 16, 2014
Date

The opinions expressed in this report are based on the information currently available to me. If additional information is brought to my attention (for example, additional documents or depositions), I may amend or supplement my opinions.

Appendix A – Patient ID Numbers

Patient Number	Name	Inmate ID
Patient #1	[redacted]	[redacted]
Patient #2	[redacted]	[redacted]
Patient #3	[redacted]	[redacted]
Patient #4	[redacted]	[redacted]
Patient #5	[redacted]	[redacted]
Patient #6	[redacted]	[redacted]
Patient #7	[redacted]	[redacted]
Patient #8	[redacted]	[redacted]
Patient #9	[redacted]	[redacted]
Patient #10	[redacted]	[redacted]
Patient #11	[redacted]	[redacted]
Patient #12	[redacted]	[redacted]
Patient #13	[redacted]	[redacted]
Patient #14	[redacted]	[redacted]
Patient #15	[redacted]	[redacted]
Patient #16	[redacted]	[redacted]
Patient #17	[redacted]	[redacted]
Patient #18	[redacted]	[redacted]
Patient #19	[redacted]	[redacted]
Patient #20	[redacted]	[redacted]