DATE OF REPORT	OUT-STANDING ISSUE Y/N	Monitoring Instrument	ITEM NO.	NON-COMPLIANCE ISSUE	CONTRACTOR RESPONSE/DATE/ CORRECTIVE ACTION TAKEN	DATE/METHOD OF CONFIRMATION BY MONITOR/COMMENTS	TDOC MANAGEMENT COMMENTS/NOTES
7/30/08	Yes	Drug Testing & Substance Abuse Treatment	2e	On 7/7/08, i/c #750932, two inmates were charged with positive drug screen. One was processed correctly. The other disciplinary report was never received by disciplinary chairperson. No hearing was held.	Warden's response received 8/1/08: The facility does not concur in this NC finding. AW conducted a thorough investigation of the drug screen procedures as it pertains to incident #750932. His findings were that no procedures were compromised by the C/O. All disciplinary and tests were completed by the C/O and properly turned in for processing and a disciplinary was initiated by the Officer. While the investigation is on-going at this point it does appear that at some point between the initiation of the DR by the U/A officer and the disciplinary reaching the D-board for hearing that it disappeared. The investigation into how the disciplinary disappeared and who is responsible is continuing, but the Drug testing policy in this case was conducted in accordance with the policy. We respectively ask that this NCR be removed as a result of the preliminary findings of this investigation. *F/U investigation*: 9/17/08. WCF has made procedural changes to enhance the disciplinary process and ensure accountability and the integrity of the process. Also some staffing changes have been made.	On 11/12/08 a NCR was issued for a reoccurrence of similar issue.	**8/26/08 CMD note**: The issue of who was responsible for mishandling the disciplinary report is not at issue. The fact remains that an inmate with a positive drug test did not receive a disciplinary hearing. The non-compliance report is valid and will stand. As an ESSENTIAL instrument item, this is subject to notification of Breach of Contract. The determination of whether to issue such notification is pending. A follow-up response by the Warden, indicating the final results of the investigation, and corrective action, will be considered in making this decision.
7/30/08	Yes	Security and Control - Counts	4f	On 7/29/08, WCFA was unable to clear the 10:30 a.m. count. This resulted in an emergency count being done with it not clearing until 12:47 p.m. **Essential item.**	Warden's response received 8/1/08: Prior to this NCR facility management had already taken steps to improve the count process. The Warden agrees that the count function is of highest priority and has personally reviewed count processes with the Assistant Warden and Chiefs, and the Unit Managers. The entire management team is focusing on count with monitoring of daily counts being conducted by all management team staff to include out counts, housing unit counts and the count room process. We are identifying where specific employees may have become lax in this process and will take corrective measures where appropriate and retraining where appropriate. No facility can expect that every employee, at every count will always be perfect, and some errors will occur in the best situations from time to time. While it is not disputed that errors were made in the referenced count; it is important to remember that the process did catch the error and the count was not cleared until rectified as is the ultimate goal.	Per letter of concern dated November 10, 2008, CM will continue to monitor this item.	**8/26/08 CMD note**: As an ESSENTIAL instrument item, this is subject to notification of Breach of Contract. The CMD was present for a discussion of this incident, which appears to have caused, in part, by an inexperienced staff member in the count room. The Associate Warden's explanation of the problem and corrective action plan is acceptable, and no Breach notification will be issued.

Instrument name and Item numbers for Liquidated Damages issues are in BOLD print

DATE OF REPORT	OUT-STANDING ISSUE Y/N	Monitoring Instrument	ITEM NO.	NON-COMPLIANCE ISSUE	CONTRACTOR RESPONSE/DATE/ CORRECTIVE ACTION TAKEN	DATE/METHOD OF CONFIRMATION BY MONITOR/COMMENTS	TDOC MANAGEMENT COMMENTS/NOTES
9/2/08	Yes	Special Management Inmates	NIN	On 8/26/08, CM requested to view PELCO camera system to ensure the administrative segregation inmates were being allowed recreation. The inmates received their recreation. However in the course of viewing PELCO, the following was observed: an inmate (medium custody) had been brought in the seg. unit for pending board status. He had not been placed in his cell, when i/m another inmate (administrative segregation custody) inmate was escorted from the shower to segregation cell 107 by one (1) officer.	Warden's response received 9/4/08: On 8/26/08, staff failed to follow procedure in escorting the A/S inmate. Staff have been properly trained with specialized segregation training. Seg. Supervisor was present but failed to monitor staff. All staff concerned will receive personnel actions for this failure to comply with procedures.	On NCR's dated 12/2/08 and 12/4/08, similar incidents occurred regarding maximum security inmates.	
9/9/08	Yes	Security and control - Counts	4f	On 9-8-08, WCFA was unable to clear the 4:30 p.m. count. An emergency count was done at 6:00 p.m. with it clearing at 6:30 p.m. twp inmates were returned by Gibson count sheriff's department at 12:47 p.m. according to the sally port logbook. Both inmates were returned to the housing unit without the count room being notified. **Essential Item.**	Warden's response received 9/15/08: It was determined that the 2 referenced inmates did in fact leave the property/intake area and went back to the units/cells they had been assigned to before they went to court. The property room supervisor admits she was busy and forgot to contact the count room and the CR officer that the two inmates had returned. As a result of this incident, the facility has implemented another step to ensure there is not a reoccurrence. Upon the arrival of any inmate(s) to the vehicle gate, the vehicle gate officer will notify the count room and the shift supervisor in addition to the property room staff making the second notification.	Per letter of concern dated November 10, 2008, CM will continue to monitor this item.	**11/10/08 CMD note:** Letter of Concern e-mailed. 10/31/08 CMD note: This is an essential item. The same item was found in non-compliance in the previous monitoring period. A notification of Breach was considered, however, since the problem was not in the count room, and the problem was discovered and corrected, as stated by the Warden, a Breach notification is being withheld. A notice of concern will be issued concerning count issues.
11/12/08	Yes	Drug Testing and Substance Abuse Treatment	2e	On 10/17/08, TOMIS incident #765290, an inmate was charged with positive drug screen. The inmate was never served the disciplinary, therefore no hearing was held. **Essential item.**	Warden's response received 11/25/08: Drug testing officer completed the disciplinary and took it to the count room to be logged and entered. Once entered on TOMIS, the DR was logged on the tracking sheet to be served. The person who picked up the disciplinary did not sign for it and we were unable to confirm who may have taken it. To prevent future occurrences, we have changed steps #7and #9 of our procedures. #7. The DR will be assigned to a staff member to be served. #9. Shift Supervisor will check the DR log to be sure that'll all disciplinaries have been served and properly logged.		**2/3/09 CMD note**: Breach notification issued 1/16/08. **12/29/08 CMD note**: This essential item was also found in non-compliance on 7/30/08. A Breach notification is pending.
12/2/08	Yes	Special Management Inmates	4f	On 11/26/08, TOMIS incident #771014, a maximum security inmate was allowed out of his cell unrestrained. He then assaulted another inmate (medium custody), who was a worker in the segregation unit. **Essential item.**	Warden's response received 12/03/08: Warden agrees that the event occurred as described. The individual employee violated policy, post orders and training in opening the door of a maximum custody inmate without a second employee and without first securing the inmate with restraints. WCFA had earlier this year completed a specialized training program conducted for staff assigned to segregation and the employee involved in this incident had completed this training. The employee responsible has been terminated.		**2/3/09 CMD note**: Breach notification issued 1/16/08. **12/29/08 CMD note**: This essential item was also found in non-compliance subsequently on 12/4/08. A Breach notification is pending for both items.

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12/4/08	Yes	Special Management Inmates	1b	TOMIS incident #771899 was a Class A incident and no one at the facility notified the Assistant Commissioner or the Commissioner's Designee of the employee's injuries. **Essential item.**	Warden's response received 12/10/08: The failure in this instance to immediately contact the A/C was a result of communications to the designated ADO or to the Warden not being made when the medical determination at the hospital was known. At the time of the incident, the injuries were not believed to be serious. The employee was adamant that he did not want outside medical treatment. He was directed to go the ER as a precautionary measure due to the possibility of eye damage. When the injuries were found to be more serious, neither the Warden or ADO were updated. Central office staff had already contacted the C/M due to the TOMIS entry. As a result a directive had been put out to all supervisors and all ADO's specifying responsibilities of contacting the A/C whenever a Class A incident occurs. The directive was provided to C/M.	**Corrective Action Verified: 2/5/09:** No further finding of non-compliance in regards to notification.	**12/29/08 CMD note**: A Breach notification is being withheld at this time, due to the apparent unusual circumstances of this incident, however, such notification may result from any future non-compliance.
12/4/08	Yes	Special Management Inmates	4f	On 12/3/08, a maximum custody inmate came out of his handcuffs and assaulted two (2) staff members, one (1) which had a serious injury. Upon review of PELCO camera system the following was observed: Other inmates were in the pod while he was being escorted from the shower; no leg restraints; at no time did either escorting officer have a hold on the handcuffs; one of the escorting officers walked away from the inmate prior to him being placed in the cell. **Essential item.**	Warden's response received 12/10/08: Warden concurs that the staff assigned to segregation on this occasion were negligent in the movement of a maximum custody inmate and failed to follow established policy and post orders regarding leg restraints. As a result of this incident and a previous incident, I have directed a Shift Supervisor be assigned to segregation indefinitely, but not less than the remainder of this year to supervise and mentor staff assigned to segregation and ensure compliance with procedures in place for that post.		**2/3/09 CMD note**: Breach notification issued 1/16/08. **12/29/08 CMD note**: This essential item was also found in non-compliance previously on 12/2/08. A Breach notification is pending for both items.
1/6/09	No	Staffing	3	On 12/27/08, the "critical" position of Segregation SCO or A/S Shift Supervisor was filled with a correctional officer. He was listed as "Acting SCO". **Essential item.**	Warden's response received 01/13/09: WCFA concedes that this was a poor decision made solely by the Captain on duty, the Captain has been counseled and corrective action has been taken. Segregation will be staffed in accordance with the approved staffing pattern and management has communicated that the supervisor cannot designate one of the C/O's as an acting SCO on the post.		**3/5/09 CMD note: The institution took disciplinary action with the Shift Supervisor who made this decision. The problem has not occurred again in 60 days. Although this item is subject to issuance of a Breach notification, the problem appears to have been cured, and no Breach will be issued at this time.**
1/6/09	No	Staffing	11b	One academic instructor position was vacant for a total of 79 days. **Essential item.**	Warden's response received 1/13/09: WCFA does not dispute that the position remained unfilled beyond the 45 day timeframe in the contract. We do believe we acted in good faith to make every reasonable effort to fill this position in a timely manner. Two applicants were selected for this position. Both applicants subsequently decided to decline the job and did not report. Deputy Commissioner approved a 30 day extension. These efforts demonstrated a commitment to D/C to actively recruit, interview and select a teacher. We respectfully request TDOC accept our good faith efforts as evidenced by the tracking spreadsheet to fill this position in a timely manner.		**3/5/09 CMD note: A breach notification is being withheld at this time. The position was filled subsequent to the Warden's response.**

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1/15/09	No	Security and Control - Counts	4f	Inmate was returned from court on 1/14/09 at 2:15 pm according to the sally port logbook. He was also on the daily move sheet as a court return. The count room officer failed to enter him back into the count. TOMIS screens LIMC/LIMD were not updated/entered until 1/15/09. Inmate was assigned to FC216 on LIMC/count room locator board, however he was actually in FC110. Staff had moved him, however this was not communicated with the count room. **Essential item.**	Warden's revised response received 1/30/09: Inmate was transported back to this facility by HCCF with the incoming chain. The count room officer thought he had been returned by the sending institution. She assigned him to HE204 at 2:40 p.m. on 1/14/09. This made TOMIS and the board correct. Count was clear. At 10:30 p.m. we completed a TOMIS count and it was discovered that he was not entered back into WCFA count. He was placed on an out count and reassigned to HE204 by the 5am count. Security of the facility was never in danger and the inmate was accounted for at all affected counts. He was assigned to a cell on LIMC and the count board was corrected. All well before count. Inmate was reassigned by M/H due to cell mate concerns and as a better choice for inmate. A disconnect occurred between M/H and U/M and countroom. To alleviate this problem all moves will be verified including move sheets and unit logs b the U/M or representative after all moves are complete.		**3/5/09 CMD note: The inmate in question may have been put on the count board at 2:40 PM, but he was NOT entered back into the count on TOMIS at that time. This was not discovered until the next TOMIS count. The counts before 10:30 PM cleared because they were not TOMIS counts. The count room needs to verify all returns and incoming chains on TOMIS to ensure that they are all entered into the facility's count as soon as they are received. Since no other issues of this sort have occurred since this incident, no Breach notification will be issued at this time.**
1/15/09	No	Security and Control - Counts	8a	Three (3) inmates were assigned to cells but were actually in other cells. **Essential item.**	In response to item 8a, you can see from C/M's statement these inmates moved themselves to other cells inside their own pod. These type moves, when they happen are found at the 10:30 id count. It was discovered at the 10 am count due to a out count being wrong. All inmates received a Class C disciplinary for interference with officers duties.		**3/5/09 CMD note: Due to the fact that the inmates moved themselves, a Breach notification is being withheld at this time. It is recommended that unit staff ensure that their attentiveness level is sufficient to prevent this from occurring.**

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7/30/08	Yes	Drug Testing & Substance Abuse Treatment	2e	On 7/7/08, i/c #750932, two inmates were charged with positive drug screen. One was processed correctly. The other disciplinary report was never received by disciplinary chairperson. No hearing was held.	Warden's response received 8/1/08: The facility does not concur in this NC finding. AW conducted a thorough investigation of the drug screen procedures as it pertains to incident #750932. His findings were that no procedures were compromised by the C/O. All disciplinary and tests were completed by the C/O and properly turned in for processing and a disciplinary was initiated by the Officer. While the investigation is on-going at this point it does appear that at some point between the initiation of the DR by the U/A officer and the disciplinary reaching the D-board for hearing that it disappeared. The investigation into how the disciplinary disappeared and who is responsible is continuing, but the Drug testing policy in this case was conducted in accordance with the policy. We respectively ask that this NCR be removed as a result of the preliminary findings of this investigation. *F/U investigation*: 9/17/08. WCF has made procedural changes to enhance the disciplinary process and ensure accountability and the integrity of the process. Also some staffing changes have been made.	On 11/12/08 a NCR was issued for a reoccurrence of similar issue. **Corrective action verified 3/9/09:** No further findings of noncompliance in regards to this issue.	**8/26/08 CMD note**: The issue of who was responsible for mishandling the disciplinary report is not at issue. The fact remains that an inmate with a positive drug test did not receive a disciplinary hearing. The non-compliance report is valid and will stand. As an ESSENTIAL instrument item, this is subject to notification of Breach of Contract. The determination of whether to issue such notification is pending. A follow-up response by the Warden, indicating the final results of the investigation, and corrective action, will be considered in making this decision.
7/30/08	Yes	Security and Control - Counts	4f	On 7/29/08, WCFA was unable to clear the 10:30 a.m. count. This resulted in an emergency count being done with it not clearing until 12:47 p.m. **Essential item.**	Warden's response received 8/1/08: Prior to this NCR facility management had already taken steps to improve the count process. The Warden agrees that the count function is of highest priority and has personally reviewed count processes with the Assistant Warden and Chiefs, and the Unit Managers. The entire management team is focusing on count with monitoring of daily counts being conducted by all management team staff to include out counts, housing unit counts and the count room process. We are identifying where specific employees may have become lax in this process and will take corrective measures where appropriate and retraining where appropriate. No facility can expect that every employee, at every count will always be perfect, and some errors will occur in the best situations from time to time. While it is not disputed that errors were made in the referenced count; it is important to remember that the process did catch the error and the count was not cleared until rectified as is the ultimate goal.	Per letter of concern dated November 10, 2008, CM will continue to monitor this item. **Corrective action verified 3/9/09:** No further finding of noncompliance in regards to this issue.	**8/26/08 CMD note**: As an ESSENTIAL instrument item, this is subject to notification of Breach of Contract. The CMD was present for a discussion of this incident, which appears to have caused, in part, by an inexperienced staff member in the count room. The Associate Warden's explanation of the problem and corrective action plan is acceptable, and no Breach notification will be issued.
9/2/08	Yes	Special Management Inmates	NIN	On 8/26/08, CM requested to view PELCO camera system to ensure the administrative segregation inmates were being allowed recreation. The inmates received their recreation. However in the course of viewing PELCO, the following was observed: an inmate (medium custody) had been brought in the seg. unit for pending board status. He had not been placed in his cell, when i/m another inmate (administrative segregation custody) inmate was escorted from the shower to segregation cell 107 by one (1) officer.	Warden's response received 9/4/08: On 8/26/08, staff failed to follow procedure in escorting the A/S inmate. Staff have been properly trained with specialized segregation training. Seg. Supervisor was present but failed to monitor staff. All staff concerned will receive personnel actions for this failure to comply with procedures.	On NCR's dated 12/2/08 and 12/4/08, similar incidents occurred regarding maximum security inmates. **Corrective action verified 3/9/09:** No further finding of noncompliance in regards to this issue.	

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9/9/08	Yes	Security and control - Counts	4f	On 9-8-08, WCFA was unable to clear the 4:30 p.m. count. An emergency count was done at 6:00 p.m. with it clearing at 6:30 p.m. twp inmates were returned by Gibson count sheriff's department at 12:47 p.m. according to the sally port logbook. Both inmates were returned to the housing unit without the count room being notified. **Essential Item.**	Warden's response received 9/15/08: It was determined that the 2 referenced inmates did in fact leave the property/intake area and went back to the units/cells they had been assigned to before they went to court. The property room supervisor admits she was busy and forgot to contact the count room and the CR officer that the two inmates had returned. As a result of this incident, the facility has implemented another step to ensure there is not a reoccurrence. Upon the arrival of any inmate(s) to the vehicle gate, the vehicle gate officer will notify the count room and the shift supervisor in addition to the property room staff making the second notification.	Per letter of concern dated November 10, 2008, CM will continue to monitor this item. **Corrective action verified 3/9/09:** No further finding of noncompliance in regards to this issue.	**11/10/08 CMD note:** Letter of Concern e-mailed. 10/31/08 CMD note: This is an essential item. The same item was found in non-compliance in the previous monitoring period. A notification of Breach was considered, however, since the problem was not in the count room, and the problem was discovered and corrected, as stated by the Warden, a Breach notification is being withheld. A notice of concern will be issued concerning count issues.
11/12/08	Yes	Drug Testing and Substance Abuse Treatment	2e	On 10/17/08, TOMIS incident #765290, an inmate was charged with positive drug screen. The inmate was never served the disciplinary, therefore no hearing was held. **Essential item.**	Warden's response received 11/25/08: Drug testing officer completed the disciplinary and took it to the count room to be logged and entered. Once entered on TOMIS, the DR was logged on the tracking sheet to be served. The person who picked up the disciplinary did not sign for it and we were unable to confirm who may have taken it. To prevent future occurrences, we have changed steps #7and #9 of our procedures. #7. The DR will be assigned to a staff member to be served. #9. Shift Supervisor will check the DR log to be sure that'll all disciplinaries have been served/properly logged. *Cure Response:* As a result of the steps outlined in the NCR response, there have been no further incidents related to the NCR. WCFA has made a concerted effort to ensure that all disciplinaries including but not limited to those issued for positive drug screens are processed and adjudicated. We are monitoring the disciplinary process on a regular basis and in addition to the response made a staffing change that we believe will improve the efficiency and accuracy of the disciplinary documentation process.	**Cure verified 3/9/09:** There were no new occurrences of the problem since the breach notification. Warden's response dated 2/17/09.	**2/3/09 CMD note**: Breach notification issued 1/16/09. **12/29/08 CMD note**: This essential item was also found in non-compliance on 7/30/08. A Breach notification is pending.

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12/2/08	Yes	Special Management Inmates	4f	On 11/26/08, TOMIS incident #771014, a maximum security inmate was allowed out of his cell unrestrained. He then assaulted another inmate (medium custody), who was a worker in the segregation unit. **Essential item.**	Warden's response received 12/03/08: Warden agrees that the event occurred as described. The individual employee violated policy, post orders and training in opening the door of a maximum custody inmate without a second employee and without first securing the inmate with restraints. WCFA had earlier this year completed a specialized training program conducted for staff assigned to segregation and the employee involved in this incident had completed this training. The employee responsible has been terminated. *Cure response:* As noted in the individual response on the NCR, the actions involving the opening of the cell housing a maximum custody inmate and the subsequent employee assault were the actions of an individual employee. This employee clearly violated facility policy, procedures and post orders and as a result was terminated. WCFA has made every effort to ensure the segregation unit is safe and operated in accordance with policy.	**Cure verified 3/9/09**: There were no new occurrences of the problem since the breach notification. Warden's response dated 2/17/09.	**2/3/09 CMD note**: Breach notification issued 1/16/09. **12/29/08 CMD note**: This essential item was also found in non-compliance subsequently on 12/4/08. A Breach notification is pending for both items.
12/4/08	Yes	Special Management Inmates	4f	On 12/3/08, a maximum custody inmate came out of his handcuffs and assaulted two (2) staff members, one (1) which had a serious injury. Upon review of PELCO camera system the following was observed: Other inmates were in the pod while he was being escorted from the shower; no leg restraints; at no time did either escorting officer have a hold on the handcuffs; one of the escorting officers walked away from the inmate prior to him being placed in the cell. **Essential item.**	Warden's response received 12/10/08: Warden concurs that the staff assigned to segregation on this occasion were negligent in the movement of a maximum custody inmate and failed to follow established policy and post orders regarding leg restraints. As a result of this incident and a previous incident, I have directed a Shift Supervisor be assigned to segregation indefinitely, but not less than the remainder of this year to supervise and mentor staff assigned to segregation and ensure compliance with procedures in place for that post. *Cure response*: As a result of the findings relating to segregation; A Shift Supervisor (Captain) was indefinitely assigned to the segregation unit to ensure that assigned staff are properly trained and supervised. A meeting was held with the Warden involving the AW Operations, Chief of Security, Assistant Chief of Security and the assigned Captain, in which, I discussed my expectations related to the operation and the supervision of the segregation unit.	**Cure verified 3/9/09:**There were no new occurrences of the problem since the breach notification. Warden's response dated 2/17/09.	**2/3/09 CMD note**: Breach notification issued 1/16/09. **12/29/08 CMD note**: This essential item was also found in non-compliance previously on 12/2/08. A Breach notification is pending for both items.
1/6/09	Yes	Staffing	3	On 12/27/08, the "critical" position of Segregation SCO or A/S Shift Supervisor was filled with a correctional officer. He was listed as "Acting SCO". **Essential item.**	Warden's response received 01/13/09: WCFA concedes that this was a poor decision made solely by the Captain on duty, the Captain has been counseled and corrective action has been taken. Segregation will be staffed in accordance with the approved staffing pattern and management has communicated that the supervisor cannot designate one of the C/O's as an acting SCO on the post.	**Corrective action verified 3/9/09:** No further finding of noncompliance in regards to this issue.	**3/5/09 CMD note:** The institution took disciplinary action with the Shift Supervisor who made this decision. The problem has not occurred again in 60 days. Although this item is subject to issuance of a Breach notification, the problem appears to have been cured, and no Breach will be issued at this time.

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1/6/09	Yes	Staffing	11b	One academic instructor position was vacant for a total of 79 days. **Essential item.**	Warden's response received 1/13/09: WCFA does not dispute that the position remained unfilled beyond the 45 day timeframe in the contract. We do believe we acted in good faith to make every reasonable effort to fill this position in a timely manner. Two applicants were selected for this position. Both applicants subsequently decided to decline the job and did not report. Deputy Commissioner approved a 30 day extension. These efforts demonstrated a commitment to D/C to actively recruit, interview and select a teacher. We respectfully request TDOC accept our good faith efforts as evidenced by the tracking spreadsheet to fill this position in a timely manner.	**Corrective action verified 3/9/09:** No further finding of noncompliance in regards to this issue.	**3/5/09 CMD note:** A breach notification is being withheld at this time. The position was filled subsequent to the Warden's response.
1/15/09	Yes	Security and Control - Counts	4f	Inmate was returned from court on 1/14/09 at 2:15 pm according to the sally port logbook. He was also on the daily move sheet as a court return. The count room officer failed to enter him back into the count. TOMIS screens LIMC/LIMD were not updated/entered until 1/15/09. Inmate was assigned to FC216 on LIMC/count room locator board, however he was actually in FC110. Staff had moved him, however this was not communicated with the count room. **Essential item.**	Warden's revised response received 1/30/09: Inmate was transported back to this facility by HCCF with the incoming chain. The count room officer thought he had been returned by the sending institution. She assigned him to HE204 at 2:40 p.m. on 1/14/09. This made TOMIS and the board correct. Count was clear. At 10:30 p.m. we completed a TOMIS count and it was discovered that he was not entered back into WCFA count. He was placed on an out count and reassigned to HE204 by the 5am count. Security of the facility was never in danger and the inmate was accounted for at all affected counts. He was assigned to a cell on LIMC and the count board was corrected. All well before count. Inmate was reassigned by M/H due to cell mate concerns and as a better choice for inmate. A disconnect occurred between M/H and U/M and count room. To alleviate this problem all moves will be verified including move sheets and unit logs b the U/M or representative after all moves are complete.	**Corrective action verified 3/9/09:** No further finding of noncompliance in regards to this issue.	**3/5/09 CMD note:** The inmate in question may have been put on the count board at 2:40 PM, but he was NOT entered back into the count on TOMIS at that time. This was not discovered until the next TOMIS count. The counts before 10:30 PM cleared because they were not TOMIS counts. The count room needs to verify all returns and incoming chains on TOMIS to ensure that they are all entered into the facility's count as soon as they are received. Since no other issues of this sort have occurred since this incident, no Breach notification will be issued at this time.
1/15/09	Yes	Security and Control - Counts	8a	Three (3) inmates were assigned to cells but were actually in other cells. **Essential item.**	In response to item 8a, you can see from C/M's statement these inmates moved themselves to other cells inside their own pod. These type moves, when they happen are found at the 10:30 id count. It was discovered at the 10 am count due to a out count being wrong. All inmates received a Class C disciplinary for interference with officers duties.	**Corrective action verified 3/9/09:** No further finding of noncompliance in regards to this issue.	**3/5/09 CMD note:** Due to the fact that the inmates moved themselves, a Breach notification is being withheld at this time. It is recommended that unit staff ensure that their attentiveness level is sufficient to prevent this from occurring.
2/9/09	No	Staffing	11a	Correctional officer position #118364 was vacant for a total of 50 days. **ESSENTIAL item.**	Warden's response received 2/15/09: The failure to fill this vacancy was due to a miscommunication. Due to staffing needs a correctional officer was promoted to a senior correctional officer before the designated time HR assigned. Failure to notify HR of the promotion date caused an overage on the correctional officer fill requirement date. WCFA did have 7 part-time officers employed during that time period who worked a total of 1,318.01 hours.		**4/3/09 CMD note: Although this is an ESSENTIAL item, a Breach notification will be withheld on this occasion. It appears that there was sufficient staff coverage for this post during the time the full time position was vacant.**

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2/9/09	Yes	Staffing	11a	Correctional officer position #118364 was vacant for a total of 50 days. **ESSENTIAL item.**	Warden's response received 2/15/09: The failure to fill this vacancy was due to a miscommunication. Due to staffing needs a correctional officer was promoted to a senior correctional officer before the designated time HR assigned. Failure to notify HR of the promotion date caused an overage on the correctional officer fill requirement date. WCFA did have 7 part-time officers employed during that time period who worked a total of 1,318.01 hours.		**4/3/09 CMD note**: Although this is an ESSENTIAL item, a Breach notification will be withheld on this occasion. It appears that there was sufficient staff coverage for this post during the time the full time position was vacant.
3/10/09	No	Medical and Mental Health Service	1b(1)	The contract requires the physician to be at WCFA sixteen (16) hours per week. During the period of 11/26/08 till 1/5/09, there was no physician at WCFA except for seven (7) hours on 12/12/08. There was no physician here from 1/29/09 till 2/9/09. The week of 2/9/09, the physician was only here 4.75 hours. The week of 2/23/09, the physician was here only 12.15 hours.	Wardens response received 3/17/09: The facility agrees that we did not provide the amount of physician hours as required by contract/staffing pattern. This occurred as a result of the departure of the physician previously employed and the subsequent decision of the doctor hired to replace him to accept other employment. We now have a contract physician committed to providing coverage for sixteen (16) hours were week. As always, we will continue to ensure that the inmates receive the appropriate medical care.		
3/12/09	No	Disciplinary Procedures	NIN	Twenty-nine (29) disciplinaries had to be dismissed. Disciplinary Board hearings were not held, nor were they continued.	Wardens response received 3/16/09: Facility concurs that this occurred as stated. The DHO reported to the Chief of Security in advance that she was going to have to be off work on the scheduled hearing date. The Chief failed to make arrangements to provide a relief DHO. Formal disciplinary action is pending as a result.		
3/23/09	No	Special Management Inmates	NIN	Twenty-one (21) punitive inmates were due a thirty (30) day mental health assessment, five (5) exceeded the timeframe.	Wardens response received 3/24/09: The Warden concurs that these inmates were not evaluated within the specified time frame. After discussing with the mental health coordinator, it was found that the errors occurred due to her using the TOMIS MGM report to develop the schedule for the evaluations. This report is not accurate for this purpose in cases where inmates receive additional sentences after initial segregation placement. She will begin using other scheduling practices that will ensure inmates are evaluated within the appropriate time period.		

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2/9/09	Yes	Staffing	11a	Correctional officer position #118364 was vacant for a total of 50 days. **ESSENTIAL item.**	Warden's response received 2/15/09: The failure to fill this vacancy was due to a miscommunication. Due to staffing needs a correctional officer was promoted to a senior correctional officer before the designated time HR assigned. Failure to notify HR of the promotion date caused an overage on the correctional officer fill requirement date. WCFA did have 7 part-time officers employed during that time period who worked a total of 1,318.01 hours.	**Corrective Action Verified: 4/28/09:** No further finding of non-compliance.	**4/3/09 CMD note**: Although this is an ESSENTIAL item, a Breach notification will be withheld on this occasion. It appears that there was sufficient staff coverage for this post during the time the full time position was vacant.
3/10/09	Yes	Medical and Mental Health Service	1b(1)	The contract requires the physician to be at WCFA sixteen (16) hours per week. During the period of 11/26/08 till 1/5/09, there was no physician at WCFA except for seven (7) hours on 12/12/08. There was no physician here from 1/29/09 till 2/9/09. The week of 2/9/09, the physician was only here 4.75 hours. The week of 2/23/09, the physician was here only 12.15 hours.	Wardens response received 3/17/09: The facility agrees that we did not provide the amount of physician hours as required by contract/staffing pattern. This occurred as a result of the departure of the physician previously employed and the subsequent decision of the doctor hired to replace him to accept other employment. We now have a contract physician committed to providing coverage for sixteen (16) hours were week. As always, we will continue to ensure that the inmates receive the appropriate medical care.	CM will continue to monitor this item on a weekly basis.	
3/12/09	Yes	Disciplinary Procedures	NIN	Twenty-nine (29) disciplinaries had to be dismissed. Disciplinary Board hearings were not held, nor were they continued.	Wardens response received 3/16/09: Facility concurs that this occurred as stated. The DHO reported to the Chief of Security in advance that she was going to have to be off work on the scheduled hearing date. The Chief failed to make arrangements to provide a relief DHO. Formal disciplinary action is pending as a result.	**Corrective Action Verified: 4/28/09:** No further finding of non-compliance.	
3/23/09	Yes	Special Management Inmates	NIN	Twenty-one (21) punitive inmates were due a thirty (30) day mental health assessment, five (5) exceeded the timeframe.	Wardens response received 3/24/09: The Warden concurs that these inmates were not evaluated within the specified time frame. After discussing with the mental health coordinator, it was found that the errors occurred due to her using the TOMIS MGM report to develop the schedule for the evaluations. This report is not accurate for this purpose in cases where inmates receive additional sentences after initial segregation placement. She will begin using other scheduling practices that will ensure inmates are evaluated within the appropriate time period.		

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3/10/09	Yes	Medical and Mental Health Service	1b(1)	The contract requires the physician to be at WCFA sixteen (16) hours per week. During the period of 11/26/08 till 1/5/09, there was no physician at WCFA except for seven (7) hours on 12/12/08. There was no physician here from 1/29/09 till 2/9/09. The week of 2/9/09, the physician was only here 4.75 hours. The week of 2/23/09, the physician was here only 12.15 hours.	Wardens response received 3/17/09: The facility agrees that we did not provide the amount of physician hours as required by contract/staffing pattern. This occurred as a result of the departure of the physician previously employed and the subsequent decision of the doctor hired to replace him to accept other employment. We now have a contract physician committed to providing coverage for sixteen (16) hours were week. As always, we will continue to ensure that the inmates receive the appropriate medical care.	CM will continue to monitor this item on a weekly basis.	
3/23/09	Yes	Special Management Inmates	NIN	Twenty-one (21) punitive inmates were due a thirty (30) day mental health assessment, five (5) exceeded the timeframe.	Wardens response received 3/24/09: The Warden concurs that these inmates were not evaluated within the specified time frame. After discussing with the mental health coordinator, it was found that the errors occurred due to her using the TOMIS MGM report to develop the schedule for the evaluations. This report is not accurate for this purpose in cases where inmates receive additional sentences after initial segregation placement. She will begin using other scheduling practices that will ensure inmates are evaluated within the appropriate time period.	**Corrrective Action Verified:** 05/29/09. No further finding of non-compliance.	

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3/10/09	Yes	Medical and Mental Health Service	1b(1)	The contract requires the physician to be at WCFA sixteen (16) hours per week. During the period of 11/26/08 till 1/5/09, there was no physician at WCFA except for seven (7) hours on 12/12/08. There was no physician here from 1/29/09 till 2/9/09. The week of 2/9/09, the physician was only here 4.75 hours. The week of 2/23/09, the physician was here only 12.15 hours.	Wardens response received 3/17/09: The facility agrees that we did not provide the amount of physician hours as required by contract/staffing pattern. This occurred as a result of the departure of the physician previously employed and the subsequent decision of the doctor hired to replace him to accept other employment. We now have a contract physician committed to providing coverage for sixteen (16) hours per week. As always, we will continue to ensure that the inmates receive the appropriate medical care.	CM will continue to monitor this item on a weekly basis.	
6/16/09	No	Security and Control - Count	4f	Inmate was placed in segregation pending disciplinary hearing. He was scheduled to be released at 10:00 a.m. on 6/15/09. According to the logbook, he was released from segregation; however LIMC was not updated until 8:28 p.m. **Essential item.**	Wardens response received 6/22/09: Warden concurs with the findings. Count room officer failed to assign his new housing assignment on LIMC. C/R Officer and OIC have been counseled on the importance of this issues and both will be given documented corrective action.		**8/6/09 CMD note: A Breach of Contract notification was sent to the contractor on 7/8/09.**
6/22/09	No	Medical and Mental Health Services	2c	Inmate had a order for a narcotic. The order was discontinued on 5/28/09. On 6/22/09, the actual count was sixty-one. CR-2264 showed the count as sixty-eight. There was a discrepancy of seven pills. No documentation could be located to account for the missing medication. **Essential item.**	Wardens response received 7/1/09: Concurs. Investigation was conducted but staff were unable to determine conclusively what happened to the missing pills. No evidence was found to suggest the medication was stolen and believe the error to be due to a failure in the processes. Changes were implemented and training was conducted to ensure the procedures were understood. HSA and CNS will monitor this daily.		

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