Ohio Department of Rehabilitation and Correction

770 West Broad Street
Columbus, OH 43222

John R. Kasich, Governor | www.drc.state.oh.us | Gary C. Mohr, Director

TO: Barry Goodrich, Warden
Lake Erie Correctional Institution

FROM: Michelle Burrows, Audit Administrator
Bureau of Internal Audits and Standards Compliance

SUBJECT: LaECI Audit Reinspection

DATE: November 15, 2012

I am enclosing a copy of the Reinspection Audit Report for the Lake Erie Correctional Institution following the inspection conducted November 7-8, 2012.

The following staff assisted with conducting the reinspection:

Michelle Burrows—Audit Administrator—Chairperson
Kathy Cole—Warden's Assistant—Belmont CI (Food Service/Unit Management/Quartermaster)
Laura Solnick—Unit Management Chief—Lorain CI (Unit Management)
Christopher Harris—Captain—Ohio State Penitentiary (Security)
Joseph Dina—Lieutenant—Ohio State Penitentiary (Security)
Bryan Smith—Health & Safety Coordinator—Ross CI (Safety/Sanitation)
Steve Olds—Health & Safety Coordinator—Correctional Reception Center (Safety/Sanitation)
Patricia Champney—Regional Nurse Administrator—NE Region (Medical)
Michelle (Shelly) Viets—Regional Nurse Administrator—NW Region (Medical)

Congratulations on the many accomplishments achieved in such a short amount of time. It is evident that the staff has taken the issues raised very seriously and have been very proactive during this process. I appreciate the support and cooperation of you and your staff during the reinspection. If you have any questions regarding the report, please feel free to contact this office.

Cc: Gary Mohr, Director
Stephen Huffman, Assistant Director
Linda Janes, Chief of Staff
Todd Ishee, Regional Director
Andrew Albright, Chief, Bureau of Internal Audits and Standards Compliance
Jayne Haverfield, Audit Administrator
Daren Swenson, CCA, Vice President, Facility Operations, Business Unit 2
Melody Turner, CCA, Managing Director, Facility Operations

Audit Reinspection Report

Facility: **Lake Erie Correctional Institution**

Original Audit Date: **September 18-20, 2012**

Date of Re-inspection: **November 7-8, 2012**

A. Reinspection Findings

During the internal management audit, there were a total of forty-seven (47) **standards** found in non-compliance. These included: three (3) Mandatory Standards, twenty-four (24) ACA Non-Mandatory Standards, and twenty (20) Ohio Standards.

Upon completion of the audit reinspection, it was found that a total of thirty-eight (38) standards were corrected. A total of one (1) standard remained in non-compliance and is beyond the control of the facility. There is also an additional three (3) non-mandatory physical plant standards, beyond the facility's control, that have been identified as non-compliant. LaECI will be preparing waivers for their upcoming ACA accreditation audit that effectively illustrates mitigation of the non-compliant conditions beyond their control. A total of eight (8) standards were found in pending compliance upon completion of corrective action. There were no standards that were classified as non-compliant that were within the facility's control.

Included within this report is a section that summarizes any significant observations that extend beyond the noncompliant standards and an overview of any recommendations follows.

B. Examination of Records

1. Accreditation File Preparation

During the initial IMA, food service file documentation was below standard. The files were reviewed and all documentation met the requirements and has been corrected.

2. Significant Incidents/Outcome Measures

The Outcome Measure/Significant Incident Summary information was reviewed and statistical information appeared to be consistent with the security level and mission of LaECI.

3. Safety/Sanitation Reinspection

A reinspection was conducted regarding the issues found during the Internal Management Audit. All issues were found to be corrected and the actual inspection report is attached.

C. REINSPECTION OF RECOMMENDATIONS/OBSERVATIONS

1. The reinspection team observed much improved, high sanitation levels within the entire facility. It was evident that staff and inmates have worked very hard to clean the areas. Showers were free of any discolor/mildew and the housing units were exceptional.

2. During the initial internal audit, it was stated that staff felt unsafe. During this re-inspection, staff stated they felt they had improved direction and it appeared their feelings of "frantic/panic" have been replaced with confidence as all staff encountered was very proud of their efforts.

3. During the re-inspection of the Lake Erie Correctional Institution chemical control throughout the institution was found in compliance. Below are observations of chemical compliance.

   a. Gas cylinders in the maintenance area were properly separated and inventoried.

   b. HMIS stickers were removed from non-hazardous chemicals in the maintenance area. Inaccurate inventory numbers were removed from containers and replaced with new.

   c. DRC Chemical list 1895 was placed in medical exam rooms as required. This replaces the use of DRC1886 Chemical Inventory Log.

   d. In the main chemical storage area of medical oxygen tanks are now being inventoried by size, HMIS stickers have been placed on all hazardous chemicals.

   e. MSDS sheets were readily available in all areas that contain chemicals.

   f. In the control of housing unit chemicals it was discovered that 5 gallon containers of non-hazardous chemicals were still being issued in chemical boxes. Additionally, a log was being used to sign chemicals in and out as well as staff were taking inmate ID's who were issued chemicals. These methods meet and exceed the DRC chemical control policy. However, the audit reinspection team worked with facility staff to simplify these additional chemical accountability processes. Simplification of these processes should ensure inconsistencies between units are minimized.

   g. All areas of the institution that store chemicals need to also have a chemical index and a list of hazardous chemical that are used in their areas. These lists need to be provided to the safety officer when this position is filled. Chemical approval forms DRC 1885 and MSDS were found to be available in all required areas.

4. The food service area was completely different from the IMA report observations. The pots/pans area has been relocated to alleviate the clutter in the kitchen area. The dry storage room has also been neatly re-organized and the spices room has been relocated and organized. Sanitation levels in this area were excellent.

5. The process for serving the inmates has become more streamlined and the time to feed the population has decreased to almost half of what it was a month ago.

6. All doors and hallways were clear of debris in food service and the inmates were constantly cleaning to ensure high sanitation levels.

7. Containers were added in a couple of locations in the food service area for hair nets and beard guards.

8. A Health Inspection was conducted during this re-inspection by the Health Department and it was found that the dish washer gauge covers were cracked and need to be replaced. This has to be corrected and clear documentation has to be provided prior to the ACA audit in December.

9. Area post orders have been revised and placed on the DRC format. All areas were reviewed and found to be accurate.

10. All emergency evacuation and preparedness issues are now corrected.

    a. Physical barriers that were not part of the original approved building plans were removed, creating an uninterrupted path of egress in the event of an emergency.

    b. Repairs have been made to the fire alarm system, assuring early warning of fire or smoke conditions

    c. Hydraulic door closers have been replaced and doors are not propped open by mechanical means, thus restoring the original integrity of fire and smoke compartments.

    d. Employees now have a concrete written procedure for emergency release, and are very knowledgeable of every aspect of the plan.

    e. An obvious education program is now in place to promote fire safety to all employees.

    f. All employees now appear to be familiar with alarm system keys.

11. New water fountains were installed to replace the non-working ones throughout the facility. The broken ones are in the process of or have been removed.

12. During review of the DOTS portal for LC hearing information, it was observed that the program was auto populating dates. It was recommended that Chief of Security Webb contact the appropriate department at OSC to determine if there is a way of correcting this.

13. In the medical area, the staffing levels are not where they should be and it was recommended the vacancies be filled as soon as possible to ensure staff has the resources needed to complete the required tasks.

14. The medical area did appear to be calm and was better organized and staff was knowledgeable of DRC policies as well.

15. The property room in segregation has been reorganized and there is much improved accountability of the inmate property.

16. There were no complaints received from inmates. The inmates were complimenting the change in atmosphere and they felt better about how the process was going. There were many compliments on the food and how much it had improved.

17. Staff needs to continue to improve in the tracking of conduct reports. There has been a significant improvement and they need to ensure they continue with completing the hearings within the required seven day timeframes.

18. The conditions of confinement within the segregation area were vastly improved and documentation of afforded privileges on the required DRC forms was compliant with applicable DRC policy. The number of triple bunked cells has also been significantly reduced to seven (7) cells at the time of the reinspection. It is anticipated this noncompliant condition will be eliminated in the very near future as collaborative transfer efforts between LaECI staff and the DRC Bureau of Classification staff action continues until completed.

D. EXIT DISCUSSION

The final exit interview was held at 1:45 p.m. on November 8, 2012 in the Warden's Conference Room with Warden Goodrich, Daren Swenson, Melody Turner and approximately 20 staff in attendance. The audit chairperson reviewed the reinspection information with staff in attendance.

Corrected Standards found in Compliance

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

Documentation was provided to show that each area has a complete list of hazardous chemicals, MSDS sheets were present during the inspection in all areas, hazard numbers were placed on the HMIS stickers, and accountability of non-hazardous cleaning chemicals was done.

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

The local fire plan was rewritten and approved by the local fire chief. The plan covered the release of inmates from locked areas in case of an emergency and staff was properly trained and knowledgeable of the local fire plan, evacuation routes, egress keys, etc.

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

Post log books were reviewed to show that Officers are documenting the required information upon arrival and being relieved from post to include emergencies, routine information, chemicals, etc.

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

Training has been conducted and staff is completing rounds in the unoccupied areas and documenting the information on the required forms.

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

A review of the log books in all the areas showed that shift supervisors and administrative staff are conducting rounds as required per DRC Policy 50-PAM-02, Inmate Communication/Weekly Rounds.

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

Post logs were reviewed and documentation was provided to show that cell/bunk and area searches are being completed as required.

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

Documentation was provided and the practice was observed to show that OC was being issued and inventoried as required. The pepper ball system has been corrected and is now in compliance with DRC policy.

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

Documentation was provided to show that contraband is being maintained as required per DRC policy. Organization of the contraband vault was very high as well as the documentation by the staff.

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

Documentation was provided to show that all conduct reports have been heard within the required seven days. LaECI staff must continue to monitor the tracking of all conduct reports when sent to the units for hearings to ensure compliance is maintained.

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

Documentation was provided to show that extensions of security control are being completed as required.

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

Staff at LaECI has put a process in place to get caught up with all conduct reports. At the time of the re-inspection, all conduct reports have been heard.

4-4253 Written policy, procedure, and practice provide that whenever an inmate in segregation is deprived of any usually authorized item or activity a report of the action is filed in the inmate's case record and forwarded to the chief security officer.

Documentation was provided and the DRC4118 forms were reviewed to ensure Unit Management staff are reviewing all inmates who are in segregation for any extended period of time.

4-4255 Revised August 2008. There is a sanctioning schedule for institutional rule violations. Continuous confinement for more than 30 days requires the review and approval of the warden/superintendent or designee. Inmates held in disciplinary detention for periods exceeding 60 days are provided the same program services and privileges as inmates in administrative segregation and protective custody.

The Chief of Unit Management is working from a database and all LC hearings are being conducted in a timely manner and is in compliance with policy.

4-4257 Revised August 2011. Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer twice per hour, but no more than 40 minutes apart, on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuous observation.

Documentation was reviewed and the practice was observed to show that rounds/activities are being completed within the required timeframes and the suicide observation logs are being maintained as required.

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

Documentation was reviewed to show that medical staff and the senior correctional supervisor are making daily visits to segregation.

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

Documentation was reviewed to ensure that laundry and barber services are being provided. Procedure and practice was observed and LaECI is now in compliance.

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

Documentation was reviewed to ensure the recreation times were being documented and if the inmate refuses, then the time of the refusal was documented.

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

Documentation was reviewed to ensure the prescriptions for therapeutic diets are specific and completed as required.

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

Documentation was reviewed to ensure that the alternative meal service is being utilized properly and it was found that LaECI is following DRC policy.

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

Review of temperatures during the reinspection showed the freezers and coolers were in compliance with policy and state codes.

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

Documentation was reviewed to ensure the time between dinner and breakfast did not exceed 14 hours and there were no discrepancies found.

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

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

A process has been put in place to monitor transfers of inmates with MRSA. The staff at Lake Erie is continuing to monitor this standard to ensure they remain compliant.

4-4425 Revised January 2006. Authorities having jurisdiction are promptly notified of an offender's death. Procedures specify and govern the actions to be taken in the event of the death of an offender.

Documentation was provided to show that security supervisors have been trained on the procedure for proper notification of individuals in the event of an inmate death that may occur while housed outside the facility.

Ohio Standards

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

Property inventories were reviewed and inmates who are placed in segregation or released back to general population have their property inventoried and sign the required form.

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

A monthly inventory was provided to show compliance. The staff has worked very diligently to come into compliance and the organization of the area has improved tremendously.

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

Sign in logs and post logs were reviewed to ensure the Executive staff is visiting the institution's living and activity areas to ensure communication.

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

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

Staff was questioned as to the process when the temperature exceeds 90 degrees and the responses were in line with DRC policy. A plan is in place to ensure compliance with this directive.

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

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

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

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

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

The facility provided the auditors with an updated confined space program to ensure compliance with DRC policy.

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

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

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

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

The local fire plan was rewritten and approved by the local fire chief. The plan covered the release of inmates from locked areas in case of an emergency and staff was properly trained and knowledgeable of the local fire plan, evacuation routes, egress keys, etc.

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

A test of the off hook alarm system was conducted and it is now in compliance. The alarm alerts the Control Center within 30 seconds of the phone being taken off the hook.

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

All nurses have state email and/or the System Access Request has been submitted. All nursing staff has been entered into the Lippincott System and has been assigned the required tests. The QIC/HCA has a system in place to monitor completion of tests.

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

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

The Ad Hoc groups have been held and all required parties were present.

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

Documentation was reviewed to ensure the inmates with special needs are being identified through the referral and red-flagging process.

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

Documentation was provided to ensure the inmates with special needs are being properly served through the ETR and IEP team procedures. The documentation was properly recorded.

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

Staff in the business office has been given access to CACTAS and are reconciling the monthly bank statements in CACTAS with the Trust fund as required.

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

Documentation was reviewed to ensure that reentry approved programs were offered. Inside/Out Dads began on November 3 with a class of 14 inmates. The class includes intensive inmates and inmates with outdates. Victim Awareness training has been scheduled and two staff are scheduled to attend. The plan is being followed as required.

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

A database has been created to monitor inmate release dates up to 180 days out. The database is updated monthly and sent to the appropriate case manager for action. All packets are up to date except those inmates who are out to court.

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

Documentation was provided to show that weekly meetings are being conducted. Email, sign in sheets, agendas, and meeting minutes were provided.

Standards Found to be Pending Compliance

4-4400 (Mandatory) Revised August 2008. When an offender is transferred to segregation, health care staff will be informed immediately and will provide a screening and review as indicated by the protocols established by the health authority. Unless medical attention is needed more frequently, each offender in segregation receives a daily visit from a qualified health care professional. The visit ensures that offenders have access to the health care system. The presence of a health care provider in segregation is announced and recorded. The frequency of physician visits to segregation units is determined by the health authority.

Even though the documentation provided demonstrated that medical staff are making rounds in segregation, continual monitoring is needed to ensure the corrective action remains in full compliance.

4-4134 Each inmate confined to a cell/room for 10 or more hours daily is provided a sleeping area with the following:

- **a sleeping surface and mattress at least 12 inches off of the floor**
- **a writing surface and proximate area to sit**
- **storage for personal items**
- **adequate storage space for clothes and personal belongings**

Each inmate confined to a cell/room for less than 10 hours daily is provided a sleeping area with the following:

- **a sleeping surface and mattress at least 12 inches off of the floor**
- **storage for personal items**
- **adequate storage space for clothes and personal belongings**

Tremendous effort was taken in transferring inmates to alleviate the triple bunking in segregation. There were seven (7) cells that were being triple-bunked during the re-inspection. Arrangements have been made to transfer these inmates to other facilities as soon as possible which will bring them into full compliance.

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

There were seven (7) cells that were being triple-bunked during the re-inspection. Arrangements have been made to transfer these inmates to other facilities as soon as possible. As soon as this is completed, the inmates in segregation will have the required 35 square feet of unencumbered space and this standard will be compliant.

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

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

The plan of action is being followed and additional monitoring is needed to ensure the Chronic Care Clinic inmates are being seen throughout the CCC processes as required.

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

The plan of action is being followed and additional time is needed to ensure the consult appointments are being handled appropriately.

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

Fourteen LaECI staff attended ORAS training on Oct. 22. The LaECI Chief of Unit Management has obtained a list of intensive/release date/needs waiting lists for program placement. Some of the staff is still waiting for access to the ORAS system but they are on track to meet the November 30 deadline for completion of RAPS/ORAS case plans.

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

Lake Erie has implemented a housing unit for orientation of incoming inmates and a database to ensure 90 day time period is met for the completion of the Prison Intake Tools (PIT). A large amount of the back log on the PITs has been completed and this effort must continue to attain full compliance.

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

Unit staff has been trained in ORAS and have completed a large amount of the back log of PIT's. They are on target to meet their approved response to non-compliance deadline in November.

Standards remaining in Noncompliance that are outside of the facility's control

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

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