



CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

OKEECHOBEE CORRECTIONAL INSTITUTION

in

Okeechobee, Florida

on

April 3-5, 2001

INSTITUTIONAL STATISTICS PROVIDED CMA on February 16, 2001				
Population	Custody	Type	Maximum Capacity	Current Occupied Beds
Adult	Close	Male	1,093	1,103

CMA Physical Health Team Leader:

Sue Sims, R.N.

CMA Mental Health Team Leader:

Kathy Pilkenton, M.S.W., M.Ed.

Physical Health Team Members:

Bernard Kimmel, M.D.
Benno Janssen, M.D.
Roberta Diehl, D.D.S.
Donna Adair, Ph.D., A.R.N.P.
Rita Hall, A.R.N.P.
Kathy Kimmel, R.N.

Mental Health Team Members:

Sherry Roth, Ph.D.
Huey Jen Chen, A.R.N.P.
Kaye Harris, R.N.

OVERVIEW

On April 5, 2001, the Correctional Medical Authority concluded a physical and mental health survey of Okeechobee Correctional Institution (OKECI), located in Okeechobee, Florida. At the time of the survey, OKECI served an adult male population of approximately 1,103 inmates assigned to medical grades 1 through 4 and psychological grades 1 and 2. Since OKECI was classified as a medical level 3 and psychological grade 2 (S2) facility, inmates requiring complex medical/dental care were routinely assigned to the institution, however, inmates requiring psychotropic medications or inpatient mental health treatment were not. A private vendor, Prison Health Services/EMSA, provides physical and mental health care services at OKECI. According to data supplied by the institution, the distribution of inmates at OKECI in terms of their medical grades, psychological grades and confinement status was as follows:

<i>Medical Grade</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>Impaired</i>	
	644	280	205	1	48	
<i>Psychological Grade</i>	<i>Mental Health Outpatient</i>			<i>MH Inpatient</i>		
<i>(S-Grade)</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>Impaired</i>
	1,037	66	0	0	0	0
<i>Confinement/ Close Management</i>	<i>DC</i>	<i>AC</i>	<i>PM</i>	<i>CM3</i>	<i>CM2</i>	<i>CM1</i>
	75	14	0	61	45	73

The goal of the survey was to determine if the physical/dental and mental health care systems in place at the institution were consistent with the standards of care established by the CMA and with prevailing professional practice standards. For a detailed description of the survey goals and processes, refer to the "Survey Process" section of this report.

A thorough review of the physical health-related systems in place at the institution, including the physical plant, administrative processes, and the provision and documentation of care generally revealed no significant departures from the Department of Corrections' standards or with standards generally accepted in the community at large. However, there were exceptions noted during the tour of the general population and confinement areas where there was no notice posted for inmates to access health care. Over-the-counter medications were not being counted at the change of each shift, which resulted in the counts being incorrect. The dorms in general were neat and clean, with the exception of the floor in one shower area, which contained soap residue. The showerhead in the impaired inmate dorm was broken.

The tour of the infirmary unit revealed a safety concern in that there was no emergency call system even though there was a video monitoring system in place. Although, a correctional officer was available in the infirmary during the day shift it was reported that during the night hours the nurse was without immediate assistance for emergencies with the inmates already housed in the infirmary.

In the review of the chronic illness clinic records several areas of concern were revealed regarding documentation and continuity of care.

In the area of mental health, several deficiencies were identified that require expedient correction. These include the lack of timeliness in record screenings of new arrivals, inmates displaying psychiatric symptoms suggesting a need for psychotropic medication evaluations, and numerous delayed confinement evaluations. The mental health findings of greatest concern were those related to a lack of safe and clinically appropriate practices utilized with self-injurious/suicidal inmates placed in "alternative housing". Additionally, information regarding allegations of inmate abuse was compiled and referred to the Department of Corrections Inspector General and the Florida Department of Law Enforcement.

At the conclusion of the survey, an exit conference was held on-site with department staff to discuss the preliminary findings of the team members. The physical health and mental health sections of this report reflect the findings and final conclusions drawn following an analysis of the information collected during the survey. Where recommended corrective actions are provided, these recommendations should not be construed as the only action required to demonstrate corrections, but should be viewed as guidance for development of a corrective action plan.