KERN VALLEY STATE PRISON

Review Period: Aug 2025 – Jan 2026
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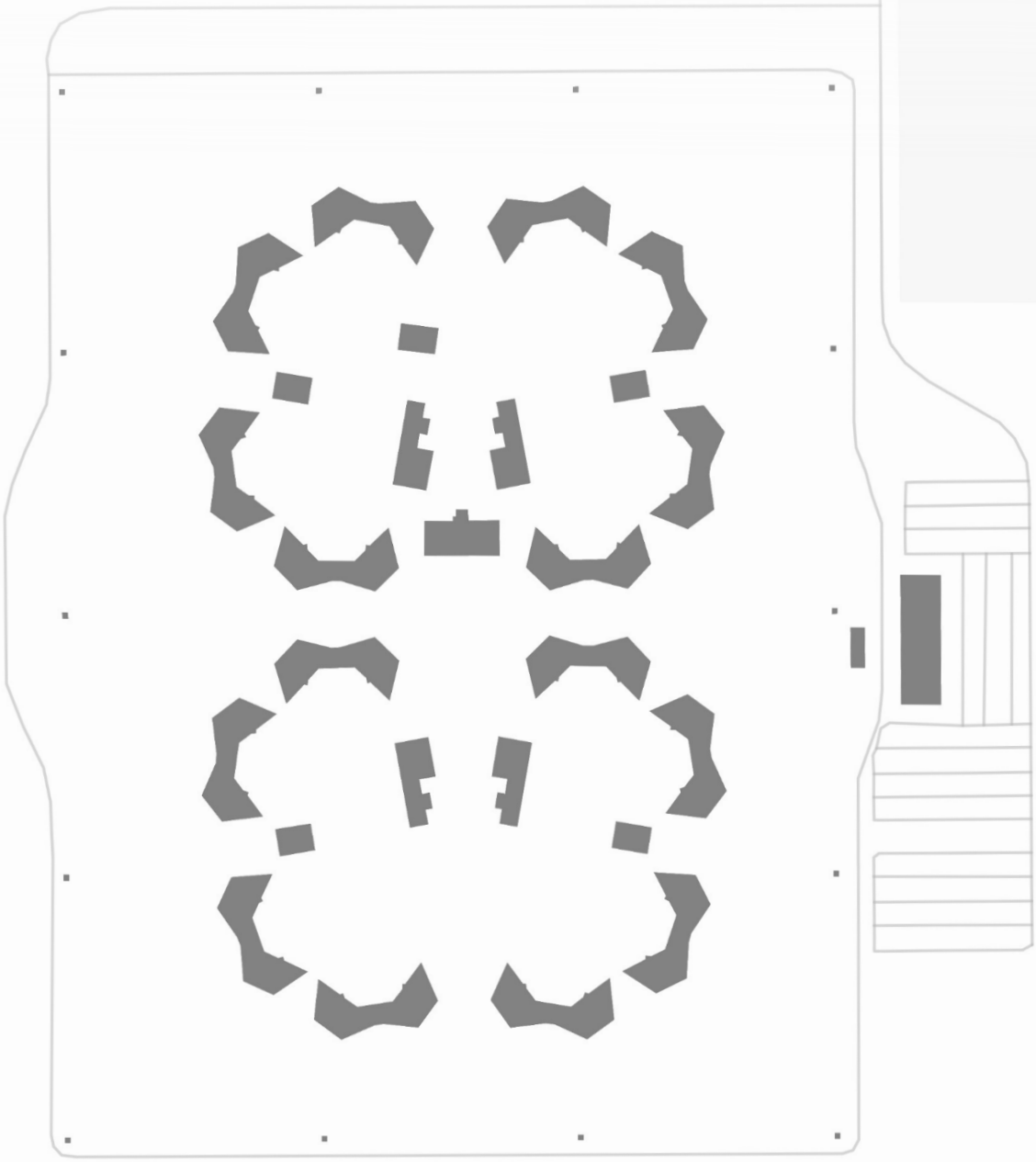
Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement



KERN VALLEY STATE PRISON

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Background

In 1990, a class of incarcerated individuals with serious mental disorders filed a federal lawsuit alleging that mental health care in California state prisons was constitutionally inadequate. Coleman v. Wilson, No. 2:90-cv-0520 (E.D. Cal.), now known as Coleman v. Newsom. The case remains active.

Following a trial, the U.S. District Court for the Eastern District of California issued findings in September 1995 identifying systemic deficiencies in the delivery of mental health care across the prison system. The court concluded that these deficiencies, including inadequate screening and access to care, insufficient staffing and training, deficient medication management practices, incomplete medical records, and shortcomings in suicide prevention, constituted deliberate indifference in violation of the cruel and unusual punishment clause of the Eighth Amendment to the Constitution. The court further found that disciplinary and housing practices failed to adequately account for the mental health needs of incarcerated individuals. 912 F.Supp. 1282.

To remedy these violations, the court approved a comprehensive plan for mental health care delivery, now set forth in the Mental Health Services Delivery System (MHSDS) Program Guide (Program Guide), and appointed a Special Master to monitor compliance.

Over the ensuing decades, CDCR undertook efforts toward compliance with the court's remedial orders. However, in 2025, the court determined that critical components of the ordered remedy had not been durably implemented. Effective September 1, 2025, the court appointed a Receiver with authority over implementation of the outstanding remedial requirements. Among the Receiver's core responsibilities is the establishment and implementation of an effective quality assurance and improvement system.

To that end, a comprehensive quality measurement framework has been developed over the course of several years with input from the parties, the Special Master, and the court. This comprises over 250 provisional Key Performance Indicators (KPIs) designed to assess each institution's compliance with the court-ordered remedy. Approximately 150 of these indicators are automated, drawing data from electronic health records and other operational databases on a continuous basis. The remaining approximately 100 indicators require onsite data collection utilizing the Continuous Quality Improvement Tool (CQIT), including direct observation of treatment delivery, assessment of treatment environments, and interviews with clinical and custody staff and patients.

As the court has explained, CQIT is central to the transition toward self-monitoring and the durable implementation of constitutionally adequate mental health care: "[T]he key indicators in CQIT signify the material provisions of the Program Guide and the Compendium that must be durably implemented in order to satisfy the Eighth Amendment." August 25, 2021, Order, ECF No. 7283at 4 (internal quotations omitted).

During 2026, the Receiver is field-testing CQIT and all other remediated indicators in what is being termed a "CQIT+ audit" at approximately two dozen institutions. The purpose of this testing phase is to determine whether the indicators function as intended and yield the information necessary to reliably assess compliance. Following this evaluation, the Receiver is charged with recommending a final set of indicators to the court.

Goals

The Receiver's overarching goals in implementing CQIT+ are to assess compliance with Program Guide requirements and build CDCR's capacity to monitor and sustain the quality of its own mental health care delivery. The latter is a prerequisite for durable reform and, ultimately, for the resolution of this case.

The Receiver seeks to use the audit process not only to assess compliance but also to identify barriers to compliance that she can address and expand effective practices across the system. Where an institution

demonstrates strength in a particular area, those practices will be documented and shared so that other facilities can learn from and adopt them.

Approach to Assessing Compliance

The Receiver's site visits integrate the CQIT tool with additional quality assurance activities, including reviews related to level-of-care placement and suicide prevention. The Receiver designed this integrated approach to provide a comprehensive picture of each facility's performance which "will allow her to implement targeted remedial measures soon after identifying noncompliance." ECF 8842 at 3. Moreover, this approach provides facility leadership with specific, actionable information in a single report while reducing the overall burden that multiple separate audit processes have imposed in the past.

Audits are conducted by the Receiver's Compliance Team (RCT), which is composed of independent subject-matter experts, regional clinical experts, and staff from the Office of the Receiver. This blended team reports to the Receiver's Senior Advisor for auditing and compliance. This approach enables the Receiver to exercise independent review of institutions while "assessing transfer of the knowledge and skill sets required to conduct internal auditing and maintain durability." ECF 8842 at 4.

During onsite visits, the RCT takes a collaborative, multi-method approach to assessing compliance and identifying strengths and areas for improvement. In addition to collecting data for the CQIT indicators, the team cross-references automated data that has been collected over time against direct onsite observations. The RCT also examines staff workflows to verify that the operational processes generating automated data are functioning as intended. To gain a fuller picture of institutional performance, the team conducts interviews with both clinical staff and patients. Throughout the visit, the RCT members work diligently to understand why an institution may not have met standards on a specific issue. This enhances the report findings and recommendations and will enable the Receiver to address broad themes and issues that require her attention.

Prior to arriving at each facility, an onsite audit schedule is created to ensure all areas are audited. The RCT reviews information about previously identified compliance concerns so the team can assess the status of those issues onsite. If critical issues are observed during the audit, the team addresses them in real time. Each day, the RCT convenes a team huddle to discuss emerging themes, identify areas where additional information is needed, and resolve any differences in assessment. At the conclusion of the visit, every RCT member who is on site drafts a summary of their overall observations for use in report drafting.

Using all this information, the process of drafting the audit report uses a report framework developed under the Senior Advisor's leadership. The RCT team-leads confer frequently with other team members to ensure the accuracy of all information included in the report. Reports reflect the team's combined expertise and are intended to help institutional leadership prioritize issues and improve performance. Draft reports are reviewed and approved by several members of the Receiver's team, including the Senior Advisor and the Deputy Receivers. The Receiver reviews and approves final reports for issuance.

This report is organized into thematic sections, each presenting both the automated KPI data and the audit team's onsite findings for that domain. In some sections, readers will observe that the automated data reflects high compliance while the onsite findings identify significant concerns, and the recommendations that follow may appear to conflict with the data table. Where the data and onsite observations diverge, the report presents both transparently so that the nature and extent of the gap is visible.

Institutional leadership is responsible for developing a corrective action plan to address the high-priority recommendations identified in the executive summary of each report within 30 days of its issuance. The facility is also responsible for acting on the remaining recommendations, and the RCT will assess the steps taken to address them on the following CQIT visit. Leadership is then responsible for implementing those plans and certifying their completion. Throughout this process, the Senior Advisor and other members of the RCT are actively involved in reviewing plans and tracking implementation. Moreover, the Senior Advisor is developing a

process to confirm that recommendations have been implemented in a way that achieves compliance and that institutions maintain compliance in those areas. All these actions are designed to ensure that these reviews drive measurable changes, rather than producing a document that goes unread.

Methodology

Data Foundation

A central prerequisite to implementing CQIT has been the completion of a court-ordered data remediation process. Beginning in 2019, the court directed a comprehensive review of CDCR's data collection and reporting practices to ensure the reliability and accuracy of the compliance data used in this case. The court subsequently ordered CDCR to undertake data remediation and validation of its mental health data management system, noting "CQIT cannot be implemented until the data on which it depends can be validated and verified." August 25, 2021, Order, ECF No. 7283 at 6.

The data remediation process has involved systematic validation of the electronic data sources that feed the automated indicators, including verification that the clinical and operational data recorded, and that accurate calculation rules are applied, consistent with Program Guide requirements. Most of this work was conducted under the supervision of the Special Master and with input from all parties in the case.

As a result, each indicator used in this report draws on data infrastructure that has been subject to this multi-year remediation and validation process. The Receiver's 2026 field-testing phase includes ongoing assessment of whether the validated data sources are producing reliable results at the institutional level.

Data Collection

Compliance data is collected through two primary methods. Automated indicators (approximately 150 of the over 250 total KPIs) draw data from electronic health records, operational databases, and other systems used in day-to-day operations. This data is collected continuously throughout the year and is available for review prior to and during onsite audits. Onsite CQIT indicators (approximately 100 KPIs) require data collection at the institution by the RCT through direct observation of treatment delivery, assessment of treatment environments, review of clinical documentation, and interviews with staff and patients.

During onsite audits, the RCT cross-references automated data against direct observations to assess consistency and identify discrepancies. The team also examines the operational workflows that generate automated data to verify that the underlying business processes are functioning as intended and producing accurate results.

Interpreting This Report

Each KPI in this report is presented with a percentage reflecting the proportion of cases, events, or observations that met the applicable standard. The following conventions are used throughout this report:

- A dagger symbol (†) indicates a small sample size (N < 20). Results based on small samples should be interpreted with caution, as they may not reliably represent overall institutional performance.
- The notation "i" designates an inverse indicator, where a lower percentage reflects better performance. To incorporate inverse indicators into aggregate compliance scores, the individual KPI percentage is subtracted from 100 (e.g., 100 – 2% = 98% compliance).
- Indicators that do not have a specified compliance threshold are excluded from the calculation of aggregate compliance scores.
- Blank boxes in the summary tables are the result of those indicators not being applicable to the institution or program being audited, or data unavailability.

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During the audit process, several indicators were identified as producing unreliable results due to technical issues in the CQIT platform, or a need for clarification in instructions or document production. These indicators have been excluded from this report and are listed in Appendix E. The development team is working to resolve these issues in time for subsequent audit reports.

Compliance Color Coding

The compliance thresholds and associated color coding used in this report reflect thresholds that were established prior to the court-ordered data remediation process and prior to the Receiver's appointment. Their use in the 2026 reports does not constitute an endorsement of these thresholds by the Receiver as the final standard for assessing compliance. Like the CQIT indicators themselves, the Receiver will be evaluating them during the 2026 field-testing phase. The Receiver will include proposed compliance thresholds when she submits recommended final indicators to the court. The thresholds in this report are defined as follows:

Color	Compliance Percentage Range
Green	≥ 89.5%
Yellow	≥ 74.5% and < 89.5%
Red	< 74.5%
Blue	No compliance threshold

Recommendations

The recommendations in this report are directed at the institution. As a result, they address deficiencies that institutional leadership has the authority and operational capacity to resolve. These include clinical supervision practices, scheduling workflows, documentation quality, staff training, internal communication protocols, and custodial procedures such as welfare check compliance and procurement. The Receiver expects institutional leadership to take action to respond to these recommendations.

Certain deficiencies identified in this report are driven by structural conditions that exceed the institution's capacity to remedy independently. These include statewide shortages of designated RHU EOP beds, insufficient physical infrastructure for group treatment, and systemwide challenges in recruiting and retaining onsite clinical staff in remote locations. Where the report identifies a structural barrier, the Receiver will take the lead in developing and implementing a resolution, whether through infrastructure investment, population management, policy revision, or coordination with CDCR and DSH leadership. Institutional leadership is not expected to solve problems it does not control, but it is expected to maximize compliance within existing constraints and to document and escalate structural barriers through the channels the Receiver's office establishes.

Where a recommendation touches both domains, for example, maximizing the use of existing treatment space (institutional) while also requesting capital investment for additional space (systemwide), the report identifies the institutional component as a near-term action item and the structural component as an issue the Receiver will address.

Executive Summary

Kern Valley State Prison (KVSP) is a Level IV, 180-degree design institution located in Kern County. It operates four Level IV Mainline (ML) facilities, a Minimum Support Facility, two freestanding Restricted Housing Units, and a 12-bed Mental Health Crisis Bed (MHCB) unit. KVSP provides treatment to approximately 1,757 MHSDS patients across a Non-Designated Mainline Enhanced Outpatient Program (EOP) with 288 beds, a designated Restrictive Housing Unit (RHU) CCCMS with capacity for 128 patients, and approximately 1,300 ML CCCMS patients. KVSP does not operate a designated RHU EOP program; patients requiring this level of care must be transferred to hub institutions.

Institutional strengths are concentrated in custody operations, emergency preparedness, and the MHCB admission process. All custody staff completed Use of Force training (100%) and suicide prevention training (100%). CPR mouth shields were carried by all officers observed. Cut-down kits were complete and standardized across all housing units. Heat Plan compliance has improved since the last quarterly custody review. Custody staff demonstrated awareness of mental health referral procedures across all yards, and 128-MH5 referral forms were available in all housing units. Timely Transfer to MHCB averaged 90%, with the Suicide Prevention and Response Focus Improvement Team (SPRFIT) Review independently confirming 99% admission within 24 hours (N=195). Custody and Mental Health Partnership Plan (CMHPP) executive leadership rounding was completed at 100% and supervisory program tours met all requirements.

Clinical strengths were observed in specific program areas. Psychiatric Technician rounds in the RHU were described as excellent by the audit team, with real-time documentation, patient engagement, and confidentiality. The RHU CCCMS group treatment program demonstrated skilled facilitation and active patient participation. The START NOW[1] group in the ML EOP featured robust therapeutic process work. The MHCB admission process functions efficiently despite high referral volume. Chapel spaces on B, C, and D yards provide confidential, adequate group treatment environments for the ML CCCMS population.

The deficiencies documented in this report are driven by a combination of structural, operational, and clinical-quality factors. The structural barriers, including a lack of sufficient group treatment space in the ML EOP, the statewide RHU EOP bed shortage, and onsite clinician vacancies, cannot be resolved through institutional corrective action alone, these are systemwide. The operational barriers (an average of ten daily lockup orders halting programming in affected yards, a 22% custody-driven cancellation rate for mental health appointments, a jumpsuit shortage in the RHU, and medical assistant redirection from telehealth support are within institutional control and can be addressed with local institutional leadership and adequate resources allocation. The clinical-quality deficits, including safety plan individualization, Suicide Risk Evaluation (SRE) documentation accuracy, Interdisciplinary Treatment Team (IDTT) case formulation, and Higher Level of Care (HLOC) non-referral documentation, are supervision and training problems that do not require additional resources to fix.

This three-part framework matters because the solution path differs for each. Systemwide problems require infrastructure, funding, or population adjustment. Local operational problems require protocol revision and custody-mental health coordination. Local clinical-quality problems require supervisory oversight, training, and accountability. The six priority recommendations below are organized by urgency and target the areas where patient safety, treatment adequacy, or both are at stake.

[1] START NOW is a structured, skills-based group psychotherapy program developed for use in correctional settings. Drawing on CBT and DBT principles, it was designed to address the high prevalence of personality disorders, impulse dysregulation, and co-occurring mental health conditions among incarcerated individuals.

Priority Recommendations

1. **Address Suicide Prevention Clinical Process Deficits: Safety Plan Quality, Suicide Risk Evaluation (SRE) Documentation, and MHCB Issue-and-Observation Order Justification.** Of fifteen safety plans reviewed for rescinded MHCB referrals, fourteen were not individualized and relied on stock phrasing. None included patient participation. Of eight MHCB patients reviewed for daily justification of issue and observation orders, only one had adequate documentation for all days on suicide precaution status. Two onsite SRE assessments observed by auditors were inconsistent with the subsequent completed documentation: the clinician did not ask about current suicidal ideation, but denial of ideation was documented. Overall SRE compliance declined from 95% to 73%. Supervisory review of discharge safety plans was completed timely for only 42% of discharges. One HQ SPRFIT corrective action plan remains open for safety planning quality; one new CAP has been assigned for MHCB issue-and-observation order documentation.

   Provide refresher safety planning training to all clinical staff, with mandatory participation for clinicians assigned to emergent referrals. Direct the MHCB program supervisor to review daily justifications for all patients' Issue and Observation Orders prior to discharge and provide real-time training as needed. Initiate monthly supervisory review of ten safety plans for rescinded MHCB referrals, with individual mentoring for inadequate plans. Respond to the two open HQ SPRFIT CAPs within established deadlines.

2. **Conduct a Comprehensive Treatment Space Assessment and Maximize Available Treatment Hours Across All Levels of Care.** KVSP's treatment space limitations affect multiple program areas documented throughout this report: the ML EOP cannot schedule the required minimum of ten hours per week of structured treatment (see Treatment Offered); individual treatment spaces in ML CCCMS and RHU CCCMS have confidentiality and safety deficiencies (see Confidential and Effective Communication; Facility and Environment of Care); and overflow populations in B1 and GP RHU have no access to structured treatment programming (see RHU: Out-of-Cell Activities/Care).

   These findings originate in different sections but share a common root: the institution does not have a current, documented accounting of what its existing physical plant can support. Without that accounting, neither the institution nor the Receiver can distinguish between deficiencies that are remediable through better utilization of existing space and deficiencies that require infrastructure the institution does not have.

   Accordingly, KVSP needs to conduct a facility-wide treatment space assessment covering every space used or potentially usable for individual contacts, IDTT meetings, and group treatment across all levels of care and housing designations, including ML EOP, ML CCCMS, RHU CCCMS, RHU GP, B1 overflow, and the MHCB. For each space, document its current use, usable hours for mental health activities per week, compliance status against each CQIT audit criterion (confidentiality, safety, size, ventilation, temperature), shared-use conflicts, and remediable deficiencies. The Receiver's Compliance Team collected detailed space-by-space data during the March 2026 onsite audit; the institution should request this data from the Regional Mental Health Administrator and use it as the foundation for the assessment rather than duplicating the work.

   Upon completion of the assessment, calculate the maximum schedulable treatment hours per week for each program at full utilization of all qualifying spaces. Compare the result against the current patient population and the applicable Program Guide treatment hour minimums. Immediately implement any changes that increase or improve treatment capacity without capital investment (including resolving scheduling conflicts between group sessions and yard time, ensuring groups run for their full scheduled duration, reconfiguring furniture in offices with egress safety concerns, and applying sound-masking or visual barrier modifications to spaces with remediable confidentiality deficiencies). Track average weekly treatment hours offered per patient monthly and demonstrate upward movement.

Structural Issue: If the completed assessment confirms that KVSP's existing physical plant cannot support the required treatment volume for its current population even at maximum utilization (which preliminary data suggests may be the case for some programs) the Receiver will evaluate options including capital investment, population adjustment, program redesign, or other remedies that are outside institutional control. The institution's completed space assessment, with supporting data, is a prerequisite for this evaluation.

3. **Resolve Barriers to Timely MHMD and MHPC Contacts.** Timely MHMD contacts averaged 63% despite 91% psychiatrist staffing, indicating a scheduling workflow problem. Timely MHPC contacts averaged 73% against a 75% fill rate that includes telehealth providers with functional limitations. Critical medication non-adherence response was at 14% and non-critical at 26%, with the non-critical rate declining from 34% to 10% over the reporting period.

   Conduct a scheduling workflow assessment to identify root causes of below-threshold contact rates. Implement revised scheduling protocols, including clarified procedures for appointment resolution and elimination of scheduling backlogs.

4. **Improve IDTT Quality & Required Staffing.** IDTTs had required attendees present 44% of the time. Only 29% of observed IDTTs demonstrated an interactive process. HQ sustainable process review showed 27% compliance with HLOC non-referral documentation, declining for five consecutive quarters. Staff demonstrated limited foundational clinical skills in case formulation, with treatment planning lacking clear linkage between mental health symptoms, functional impairments, and diagnosis.

   Develop and implement a structured IDTT quality improvement plan including a standardized checklist, supervisory observation, direct feedback, and training on case formulation, treatment goal development, and level-of-care decision-making. Integrate HLOC documentation improvement into this initiative. Address barriers to primary clinician attendance in IDTT by reviewing provider assignment and scheduling practices.

5. **Address Security Welfare Check Deficiencies in Restricted Housing.** Onsite observation identified staff completing welfare checks through partially covered windows and blacked-out cells and accepting verbal confirmations in lieu of visual observation of living, breathing individuals. B1 overflow welfare check intervals were not staggered as required. Guard One electronic logs in RHU 1 and 2 showed 91% and 88% compliance on timing, but timing compliance without observational quality does not fulfill the clinical safety purpose of the check.

   Retrain all RHU staff on welfare check requirements, emphasizing that each check requires direct visual confirmation of a living, breathing individual free from obvious injury. Initiate weekly supervisory audits of welfare check quality across all RHU settings, including B1 overflow.

6. **Conduct a Retrospective Review of Mood Stabilizer and Antipsychotic Diagnostic Monitoring and Implement Prospective Safety Tracking.** Valproic acid therapeutic level monitoring averaged 46%. CBC and CMP monitoring for valproic acid averaged 53% and 51% respectively. Lithium CMP monitoring averaged 64%. These medications have narrow therapeutic indices where missed monitoring can result in toxicity, organ damage, or subtherapeutic dosing. Antipsychotic metabolic monitoring showed sustained deficits: lipid monitoring 62%, blood sugar 73%, thyroid 73%. Ensure staff are aware of MPAIP monitoring timelines.

   Conduct a retrospective review of all patients prescribed mood stabilizers (valproic acid, lithium, carbamazepine, oxcarbazepine) during the reporting period to confirm that required laboratory monitoring has been completed or is now scheduled. Identify and address the root cause of the monitoring gap. Implement a prospective tracking system for mood stabilizer lab monitoring. Extend the review to antipsychotic metabolic monitoring measures showing sustained deficits. Provide MAPIP training on updated monitoring timelines for all prescribing staff.

Institution's Operational Perspective

Kern Valley State Prison (KVSP) is a high-security institution whose primary mission centers on 180-degree design housing for custody Level IV, Mainline and Restricted Housing residents. The institution comprises four Level IV Mainline facilities (A, B, C, D), each with eight 180-degree design housing units, one Minimum Support Facility (MSF), two freestanding Restricted Housing Units, and a 12-bed Mental Health Crisis Bed (MHCB) unit within the Correctional Treatment Center (CTC).

Facility	Function	MH Population
A, B (Level IV ML)	General Population; 8 housing units each (180-degree design)	ML CCCMS
B1	RHU overflow housing	RHU MH overflow
C, D (Level III & Level IV SNY)	Sensitive Needs Yard; C6, C7, C8 = ML EOP housing	ML CCCMS + ML EOP
RHU-1 (standalone)	Designated RHU CCCMS	RHU CCCMS
RHU-2 (standalone)	RHU GP; also houses RHU EOP and CCCMS overflow	RHU GP + overflow
CTC	Correctional Treatment Center; contains 12-bed MHCB	MHCB
M (MSF)	Minimum Support Facility; outside secure perimeter (Level I)	ML CCCMS

SNY = Sensitive Needs Yard. ML = Mainline. CTC = Correctional Treatment Center.

Mental Health Program Scope: KVSP provides treatment to approximately 1,757 MHSDS patients. Treatment programs include the 12-bed MHCB, a 288-bed Non-Designated Mainline EOP housed in Buildings C6, C7, and C8, approximately 250 beds for RHU residents with designated capacity for 128 RHU CCCMS patients in RHU-1, and approximately 1,300 ML CCCMS patients across all yards including the MSF. RHU-2 serves the General Population and houses RHU EOP and CCCMS overflow patients who cannot be accommodated in designated programs due to bed shortages. B1 serves as additional overflow housing for RHU mental health patients.

Staffing and Recruitment: During the review period, staffing has improved with the addition of eleven onsite clinicians. Six newly hired medical assistants support telehealth providers in the ML CCCMS program. The combined MHPC fill rate during the reporting period was 75%, including telehealth providers. Staff Psychiatrist positions averaged 91% filled, including telehealth positions. The Senior Psychiatrist (Supervisor) position was vacant for the full reporting period. Senior Psychologist (Supervisor) positions were filled at 52%.

Recruitment remains challenging due to competition from private-sector employers offering higher compensation. Shortages of onsite Primary Clinicians impact the institution's ability to meet the mental health mission. The institution has implemented internship and practicum programs to build a longer-term recruitment pipeline.

Operational Environment: KVSP's Level IV, 180-degree design population, presents distinct operational challenges. During the reporting period, 1,583 Incident Reports were recorded, with the ML EOP averaging 42 incidents per month. An average of ten daily lockup orders related to violence, drug use, and safety concerns halt programming across affected yards. In February 2026, 44 potential overdose incidents were reported, 34% within the three ML EOP housing units. These conditions directly affect access to care: scheduled mental health contacts are canceled, group sessions are disrupted, and staff are diverted from clinical duties to respond to security events. Custody-driven appointment cancellations averaged 22% over the reporting period.

The RHU overflow population creates a second operational challenge. Patients awaiting transfer to designated RHU EOP beds at hub institutions (KVSP does not operate a designated RHU EOP program) remain in overflow settings where treatment space and clinical programming are not available. Patients in RHU EOP and CCCMS overflow received 0% of the required structured treatment hours during the reporting period.

While outside the scope of the audit and the Coleman remedy, we note that KVSP recently added about 60 new corrections officers. This staffing may support greater access to care despite the challenging operational environment.

Clinical Programs and Initiatives: KVSP has implemented several programs aimed at suicide prevention and patient engagement. These include a Veterans Peer Mentor program, EOP Mentor Guides, a Peer Support Specialist program, and Parole Preparedness and Lifer's Groups for the CCCMS population. The mental health leadership team collaborates with the Inmate Advisory Council (IAC) regarding group topics and treatment opportunities. Additional programming and educational opportunities are available through the Division of Rehabilitative Programs (DRP), Behavioral Health Reintegration, Education, Integrated Substance Use Disorder Treatment (ISUDT), Kern County Behavioral Health Recovery Services, and Kern County Veteran's Services. The institution also partners with resident contributors to The Pioneer, a resident-led newspaper, to raise awareness of mental health issues.

Infrastructure: Treatment space is the most significant infrastructure constraint. The ML EOP does not have sufficient group treatment space to schedule the required minimum of ten hours of structured treatment per week for its current population. A Capital Outlay project has been requested for modular office space, which would allow conversion of current offices into treatment areas for the EOP and RHU CCCMS programs. The conversion of Lower C yard to a Level III program has reduced incidents and increased access to programming on that yard, and institutional leadership views this as a model for potential expansion.

Access to Care: Confidential and Effective Communication

These indicators assess whether mental health treatment is delivered in settings that protect patient privacy and whether communication barriers are addressed so that patients can meaningfully participate in their own care.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg
Effective Communication Achieved	97%	97%	97%	97%	96%	95%	97%
Group treatment in a confidential setting	95%	92%	99%	97%	99%	99%	97%
IDTTs in a confidential setting	96%	98%	99%	98%	99%	98%	98%

✓ **Strengths**

Automated data shows stable, high compliance across all three indicators over the six-month period, with no month falling below 92%. Confidential IDTT and group treatment both trended upward. These results are consistent with onsite observations in several program areas: chapels used for ML CCCMS group treatment on B, C, and D yards were confidential, and IDTT spaces were adequate across all levels of care. Receiving and Release (R&R) initial health screenings observed by nursing auditors were conducted in confidential settings with suicide prevention posters appropriately posted. Individual treatment spaces in the Minimum Support Facility (MSF) were fully confidential.

⚠ Concerns

While automated data reflects high compliance, onsite observation revealed physical conditions in several treatment areas that compromise confidentiality in practice. The automated indicator captures whether the clinician documented the encounter as confidential, but it does not assess whether the physical environment in which the encounter occurred actually met confidentiality standards. The following findings describe spaces where the physical environment falls short of confidentiality requirements, even though the encounters conducted in them were documented as confidential.

Individual treatment spaces in ML CCCMS housing units on A, B, C, and D yards achieved sound confidentiality but not visual confidentiality, since sessions are visible from the dayroom. In the ML EOP, offices located adjacent to patient restrooms have compromised sound confidentiality, with conversations audible through ventilation systems. Custody officers in the ML EOP MH clinic reported that therapy conversations could be overheard in the clinic bathroom. In RHU CCCMS, patients in cells adjacent to treatment rooms reported being able to hear conversations between patients and their providers. Three of five RHU CCCMS treatment rooms lack seating for patients during clinician contacts. Without seats installed in the therapeutic modules, patients are required to stand for the entirety of their clinical encounter.

Group treatment spaces in the A and B yard gyms can meet confidentiality standards when only one group is held in the space at a time. However, if multiple groups are conducted simultaneously in the same large space, confidentiality can no longer be ensured, as discussions from one group may be overheard by participants in another. This concern is addressed further in the Facility and Environment of Care section. The MSF visiting room is suitable for confidential group treatment.

RHU overflow settings present a distinct concern. In B1 overflow, treatment space is limited to four non-confidential treatment modules, and most individual encounters occur at cell front. Only CCCMS patients in RHU2 overflow are receiving confidential individual encounters; other overflow patients are not (B1). (See RHU: Out-of-Cell Activities/Care for related findings.)

Recommendations

1. Improve Sound Confidentiality in Identified Treatment Spaces: Identify all treatment spaces where sound transfer has been documented or reported. Install sound-masking measures in the treatment spaces.
2. Improve Visual Confidentiality in ML CCCMS Housing Unit Offices: The treatment space deficiencies identified in this section are part of a facility-wide pattern documented across multiple domains. Priority Recommendation 2 directs the institution to conduct a comprehensive treatment space assessment covering all levels of care and program areas, using data collected by the Receiver's Compliance Team during the March 2026 audit as a foundation. The institution should implement remediable improvements identified in this section as immediate actions while the broader assessment is completed. See Priority Recommendation 2 for the full scope.
3. Align Automated Documentation with Observed Conditions: Direct clinical staff to document any encounter conducted in a non-confidential setting as "non-confidential" in EHRS. Establish a regular supervisor review of a random sample of data entry practices to ensure accuracy.

Access to Care: Timely Access

The Program Guide requires that patients receive timely access to mental health services. These indicators measure institutional capacity to deliver scheduled contacts within mandated timeframes and to maintain accessible referral pathways between custody and mental health staff.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
IRU Reviews Completed Timely	100%†	80%†	100%†	100%†	100%†	75%†	91%	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure	0%†	100%†					75%†	
RHU GP Screens	90%	87%	100%	92%	81%†	95%†	91%	
RHU Pre-Screen	82%	89%	84%	85%	81%	89%	85%	
Timely IDTTs (v2.0)	46%	53%	62%	63%	60%	63%	58%	
Timely MH Referrals (v2.0)	73%	77%	83%	85%	87%	85%	81%	
Timely MHMD Contacts (v2.0)	53%	71%	69%	63%	59%	66%	63%	
Timely PC Contacts (v2.0)	56%	76%	80%	74%	74%	75%	73%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available and Accessible to Housing Unit Staff								100%

✓ Strengths

Custody-mental health referral infrastructure is functioning well. CDCR 128-MH5 Mental Health Referral Chronos were available and accessible across all housing units (100%), and all custody staff interviewed demonstrated awareness of their responsibility to initiate mental health referrals (100%).

RHU screening processes are at or near compliance thresholds. IRU Reviews were completed timely at 91%, though all months carried small sample sizes. Timely MH Referrals trended upward from 73% to 85–87% over the reporting period, approaching the compliance threshold.

⚠ Concerns

Three of the six ongoing performance indicators in this section are in the red range, and the pattern is persistent: Timely MHMD Contacts (63%), Timely PC Contacts (73%), and Timely IDTTs (58%), have remained below compliance thresholds for the full reporting period. The causes are both structural and operational. Staffing shortages create backlogs, program interruptions cancel scheduled contacts, and workflow barriers prevent full utilization of available providers.

Timely MHMD Contacts averaged 63% despite nearly full psychiatrist staffing: Per the staffing table, Staff Psychiatrist positions averaged a 91% fill rate during the reporting period. The Senior Psychiatrist Supervisor position was vacant throughout the reporting period. Staff reported uncertainty about how to appropriately cancel and reschedule appointments, which contributes to scheduling inefficiency.

Timely PC Contacts averaged 75%: The combined MHPC fill rate during the reporting period was 75%, including telehealth providers. However, Medical Assistants supporting telehealth providers reported SRNs routinely pull them from the ML CCCMS program to cover medical lines, which further reduces the availability of MHPC's to see patients. (See also the Staffing section for related findings.)

Timely IDTTs averaged 58%, trending upward from 46% in August to 63% in January: While the upward trend is noted, the indicator has not approached the compliance threshold during any month of the reporting period. The IDTT timeliness deficit results in backlogged appointments and is attributed to, at least in part, the staffing shortage and program-interruptions described above. Additional contributing factors are discussed in the Quality of Care: Care Access section.

Operational barriers to patient movement significantly constrain access to care: An average of ten daily lockup orders related to violence and drug use halt programming across affected yards, extending wait times for initial and routine services. Custody-driven appointment cancellations averaged 22% over the reporting period (see Access to Care: Appointments), with January reaching 32%.

Jumpsuit shortages in the RHU have prevented patients from leaving their cells for treatment and healthcare appointments: This barrier has persisted for approximately one year and was identified as a contributing factor to a suicide at KVSP in 2025. The decedent did not refuse mental health contacts, but custody was unable to facilitate the appointment due to lack of available out-of-cell clothing. During the reporting period, even paper jumpsuits (generally used when no other option is available) were inconsistently available to patients that needed to attend mental health appointments. This is an ongoing urgent concern that directly affects access to care for patients in restricted housing and has not been resolved despite the institution's awareness of the issue and its impact.

Patient interviews corroborated the data: ML CCCMS patients on C yard reported being made to wait outside the committee room on the yard for extended periods before IDTTs, leading some to refuse their IDTT rather than continue waiting. Of eight RHU CCCMS patients interviewed, only two reported being seen as often as required, which is consistent with performance report data. ML EOP patients expressed frustration with frequent cancellations and reported that ducated appointments were not always honored even in the absence of a modified program schedule. Patients across programs reported that medication distribution lines run late, creating cascading delays for morning appointments. This was also corroborated by staff during the staff interview who reported that breakfast will delay pill lines, which will delay other mental health programming.

Recommendations

1. Conduct a Psychiatric Scheduling Workflow Assessment: Initiate a focused review of MHMD scheduling practices, documenting cancellation and no-show patterns, scheduling conflicts, and average appointment duration. Identify and implement specific workflow changes (revised local scheduling protocols, clarified procedures for appointment resolution, elimination of scheduling backlogs). Track MHMD contact completion rates monthly to confirm improvements are increasing compliance rates.
2. Resolve the RHU Jumpsuit Shortage: Identify the root cause of the shortage (procurement, laundry operations, inventory management, or other), determine the number of jumpsuits required to eliminate the barrier, and establish a timeline for resolution. Once resolved, confirm that no patient in the RHU is unable to attend a mental health appointment due to lack of appropriate clothing. Coordinate with custody leadership and Plant Operations as needed from root cause analysis to confirmation of resolution.
3. Reduce the Impact of Program Interruptions on Scheduled Mental Health Services: Convene a joint meeting between mental health and custody leadership to review lockup order patterns, identify which orders could permit continued mental health programming (e.g., partial lockdowns that do not affect treatment areas), and develop a protocol for rescheduling cancelled appointments quickly. Implement the revised protocol and begin tracking same-week rescheduling rates for cancelled appointments.

Access to Care: Timely Transfers

The Program Guide establishes timeframes for transferring patients to the appropriate level of care once a clinical determination has been made. These indicators measure whether patients referred to a Psychiatric

Inpatient Program (PIP), to a designated RHU CCCMS program, or out of a GP RHU standalone unit are transferred within required timeframes, and whether referral submissions to the Institutional Review Unit (IRU) are timely.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU	86%†	75%†	100%†	50%†	100%†	50%†	78%
Timely Transfer of MHSDS Patients out of GP RHU Standalone Units	0%	0%	2%	1%	1%	0%	1%
Timely Transfers to EOP (v2.0).	100%	100%†	100%	100%†	100%†	100%†	100%
Timely Transfers to PIP	67%†	83%†	100%†	0%†	33%†	80%†	72%
Timely Transfers to RHU CCCMS	21%	5%	6%†	5%	8%	3%	8%

✓ **Strengths**

Timely transfers to EOP were consistently on time throughout the reporting period.

⚠ **Concerns**

Timely Transfers to RHU CCCMS: In the best month (August), only 21% of patients were transferred timely; in January, 3% were transferred within the required timeframe. Based on the 6-month average, patients clinically determined to need a designated RHU CCCMS treatment program waited beyond mandated timeframes in 92% of cases. During the wait, these patients remain in settings without the programming structure their level of care requires.

Timely Transfers of MHSDS Patients out of GP RHU Standalone Units: At 1%, this process is functionally non-operational. Four of six months showed 0% compliance. MHSDS patients who have been approved for transfer out of the GP RHU remain there indefinitely, which constitutes continued exposure to the restrictive conditions of a setting that has been determined to be inappropriate for their needs. This reflects the statewide shortage of beds for this population, not a failure on the part of KVSP to move patients once a bed is available. There also various drivers contributing to bed demand that should be investigated further.

Timely Transfers to PIP averaged 72%, with extreme month-to-month volatility: The rate ranged from 0% in November to 100% in October. The small denominators (in every month) mean that individual percentages are volatile. The pattern across months is more informative than any single value: PIP transfers are not reliably timely, even though some months achieve compliance. The 0% in November and 33% in December warrant investigation to determine whether the delays were caused by receiving-facility bed availability, or transport delays.

Timeliness of Acute/ICF Referral Submission to IRU: At 78%, approximately one in five referrals were submitted late. The month-to-month variation (50%–100%) suggests inconsistent administrative processing rather than a systemic barrier. The 50% months (November and January) indicate that when the referral process breaks down, it affects half the cases. Because referral submission is a prerequisite for the transfer itself, delays at this step cascade into the PIP transfer timeliness indicator.

Recommendations

1. Identify and Address the Barriers to Timely RHU CCCMS Transfers: Ensure each patient retained in an RHU past the approved transfer timeline is there for a justifiable reason. Any patient who has been approved to return to the General Population should be moved the same day they are eligible for transfer. Continue working with the Regional Mental Health Administrator to request expedited clinical transfers for any patient in an overflow setting who may be at clear risk of clinical decompensation.

Develop a system of review that addresses custodial reasons for patients who move back and forth between RHU and GP settings frequently due to self-reported safety concerns.

Review all patients currently awaiting transfer to designated RHU CCCMS housing to determine the specific barrier for each case (bed unavailability, classification processing, custody transport, or other). Coordinate with the Regional Mental Health Administrator and classification staff to develop a resolution plan, including identification of receiving beds and a protocol for prioritizing transfers based on clinical acuity. Track time-from-determination-to-transfer monthly and report in the MHPSC.

2. Investigate and Resolve the GP RHU Discharge Failure: Review all MHSDS patients currently housed in the GP RHU who have been approved for transfer to determine the specific barrier (receiving bed, classification, transport, or administrative). Implement a process to ensure approved transfers are executed within the mandated timeframe, including designated responsibility for tracking pending transfers and escalation procedures.
3. Some of the deficiencies identified in this section are driven in part by the statewide shortage of designated beds, which is outside institutional control. The institution cannot transfer patients to beds that do not exist. However, the institution is responsible for ensuring that patients awaiting transfer receive treatment services available in their current setting, that pending transfers are tracked and prioritized by clinical acuity, and that cases involving clinical deterioration are escalated immediately through the Regional Mental Health Administrator. The Receiver recognizes that the systemwide shortage of designated beds at the required levels of care is a structural barrier affecting multiple institutions and will address it as part of her broader remedial planning, including evaluation of bed capacity, population distribution, and institution resources.

Access to Care: Appointments

These indicators measure whether scheduled appointments are completed or refused on the day scheduled and the rate at which custody-related factors result in appointment cancellations. Appointments Cancelled Due to Custody is an inverse indicator, a lower percentage reflects fewer custody-driven cancellations.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	16%	28%	10%	27%	16%	32%	22%

⚠ Concerns

Custody-driven cancellations averaged 22% and are unpredictable: The rate ranged from 10% in October to 32% in January, a threefold swing. At 22%, roughly one in five scheduled mental health appointments were cancelled for custody-related reasons. The volatility suggests the cancellation rate is driven by episodic events (yard incidents, lockdowns) rather than a stable structural factor, which means it is partially amenable to operational intervention. The causes and recommended interventions are addressed in the Timely Access section (see Recommendation 3: Reduce the Impact of Program Interruptions).

Recommendations

1. **Custody-driven cancellations:** The causes and recommended interventions are addressed in the Timely Access section (see Recommendation 3: Reduce the Impact of Program Interruptions).

Access to Care: Treatment Offered

The Program Guide specifies minimum weekly structured treatment hours by level of care: ten hours for Enhanced Outpatient Program (EOP) patients and ninety minutes for Correctional Clinical Case Management System (CCCMS) patients in Restricted Housing Units (RHU). This indicator measures the percentage of patient-weeks during which those minimums were met. It is the most direct measure of whether the institution delivers the volume of treatment its patient population requires.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg
Treatment Offered (Structured): non-PIP	15%	14%	21%	17%	15%	14%	16%

✓ **Strengths**

Group treatment observations identified areas of clinical quality within the treatment that is being delivered. RHU CCCMS groups benefited from skilled facilitation by the recreational therapist, with active patient participation and meaningful engagement with coping skills content. The Start Now group in the ML EOP, facilitated by a Marriage and Family Therapist, featured robust therapeutic process work and enthusiastic patient involvement. A nursing-facilitated Borderline Personality group used structured materials effectively and ensured all participants contributed. These observations demonstrate that individual clinicians can deliver quality treatment when programming occurs.

⚠ **Concerns**

Treatment Offered: At 16%, the aggregate indicator means that on average, during any given week, fewer than one in six patients were offered treatment meeting the Program Guide minimum during the reporting period.

The ML EOP Treatment Scheduled: Though the required number of hours of treatment offered is 10, there was not a single week in the review period where the average number of hours of treatment scheduled for this population reached 10. The required minimum is 10.0 hours. Even if every scheduled session ran as planned with no cancellations, no lockdowns, and full patient attendance, the program would still fall short. Only 4% of ML EOP patients were scheduled for the minimum hours, and the average patient was offered approximately half of the required amount (5.1 hours).

RHU CCCMS: Achieved 53% compliance with the 90-minute weekly minimum with an average of 0.9 hours (54 minutes) offered per patient. While closer to the threshold than the ML EOP, the program is still not offering the required amount of treatment to all its patients. Contributing factors include scheduling conflicts between group sessions and yard time, delays in beginning sessions due to custody escort procedures, and sessions ending before the scheduled time. Staff challenges in securing patients in restart chairs were also observed (i.e., the officer needed instruction on how to secure a patient to a restart chair when the patients were being loaded into the chairs for a group) which delayed scheduled start times for treatment services and reduced the total time for those services to be offered.

Group treatment quality was uneven: While the START NOW group and RHU CCCMS groups demonstrated clinical quality, other observations were less favorable. One ML EOP group facilitated by a recreational therapist ended 35 minutes after it began because the facilitator ran out of material. Multiple groups across programs started late and ended early.

Recommendations

1. Conduct a Treatment Space Capacity Audit for ML EOP: The treatment space deficiencies identified in this section are part of a facility-wide pattern documented across multiple domains. Priority Recommendation 2 directs the institution to conduct a comprehensive treatment space assessment covering all levels of care and program areas, using data collected by the Receiver's Compliance Team

during the March 2026 audit as a foundation. The institution should implement remediable improvements identified in this section as immediate actions while the broader assessment is completed. See Priority Recommendation 2 for the full scope.

2. Maximize Utilization of Available Treatment Hours: Ensure that every available treatment hour identified through the space audit is used. Schedule all ML EOP patients to the maximum available hours, eliminate scheduling conflicts between group sessions and yard time, and direct that all groups run for their full scheduled duration. Track average weekly treatment hours offered per patient monthly and demonstrate upward movement toward the compliance threshold.

Custody and Mental Health Partnership Plan

The Custody and Mental Health Partnership Plan (CMHPP) established the framework for collaborative care delivery between custody and mental health staff. These indicators assess both whether required activities occur and whether mandated participants are present.

Indicator	Onsite Audits
CMHPP MH Daily Huddles	40%
CMHPP MH Huddle Documentation of Required Attendees	60%
CMHPP MH Huddle Documentation of Supervisor Attendees	39%†
CMHPP Monthly Executive Leadership Joint Rounding	100%
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives	88%
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	100%†
Custody Staff CMHPP Annual Training	100%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	100%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	100%
Quarterly Partnership Round Table Training Completed as Required	100%†
Required Staff Attendance of Quarterly Partnership Round Table Training	33%†

✓ **Strengths**

Executive leadership engagement with the CMHPP is strong. Monthly executive leadership joint rounding was completed as required (100%), conducted in all mental health programs (100%), and attended by required executives 88% of the time. This level of leadership participation provides the institutional foundation for custody-mental health coordination.

Supervisory-level partnership activities are compliant. ML CCCMS weekly supervisory meetings occurred with all required attendees (100%), and monthly joint supervisory program tours were completed with required attendees (100%). Custody staff CMHPP annual training was at 100%. All required Quarterly Partnership Round Table Trainings were completed (100%).

⚠ Concerns

Daily huddles: CMHPP daily huddles occurred only 40% of the time, and supervisor attendance was documented 39% of the time. Huddle attendance logs were missing for multiple days each month across all programs (ML EOP, RHU CCCMS, ML CCCMS, and MHCB), indicating that meetings either did not occur or were not documented.

The ML EOP custody supervisor did not attend during any of the weeks audited. When asked, the supervisor attributed the absences to incidents on the yard and the way the meeting is run. The one ML EOP huddle observed during the site visit was conducted via computer with participants communicating through a chat function, which reduced engagement and did not function as a collaborative discussion. For an EOP program experiencing an average of 42 incident reports per month, the daily custody-mental health meeting is the mechanism through which the two disciplines coordinate responses to the very conditions that are driving programming disruptions. MHCB huddles had required members present approximately 50% of the time and had missing logs for several days each month.

Quarterly Partnership Round Table Trainings were completed but poorly attended: While all training occurred as required (100%), only 33% had the required staff in attendance. The training is occurring, but the people who need the training are not present.

Recommendations

1. Restore Daily Huddle Compliance Across All Programs: Initiate weekly supervisor audits of huddle attendance and documentation across all programs (ML EOP, ML CCCMS, RHU CCCMS, and MHCB). Require that findings are reported in the weekly area report to the Chief of Mental Health and summarized monthly in the Mental Health Program Subcommittee (MHPSC).
2. Ensure Required Staff Attend Quarterly Partnership Round Table Trainings: Identify the specific barriers preventing required staff attendance (scheduling conflicts, competing duties, unclear expectations about who is required). Implement a pre-training notification and attendance confirmation process. Track attendance by name and discipline at the next scheduled training and report results to institutional leadership.

Facility and Environment of Care

Treatment spaces used for individual contacts, IDTT meetings, and group sessions should meet standards for confidentiality, safety, adequate size, and environmental controls including ventilation and temperature. These indicators assess whether the physical environments in which mental health care is delivered support therapeutic engagement and protect patient privacy. Compliance is determined through direct observation during onsite audits.

Indicator	Onsite Audits
Adequate Group Treatment Spaces	75%†
Adequate IDTT Spaces	44%†
Adequate Individual Treatment Spaces	29%

Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	5	No	Missing or inadequate conference table (2)
	Group	6	Partial	A, & B, (2)
	Individual	28	No	Non-compliance due to windows compromising confidentiality (28)
ML EOP	IDTT	1	Yes	
	Group	5	Yes	
	Individual	7	Yes	
RHU CCCMS Standalone	IDTT	1	Yes	
	Group	1	Yes	
	Individual	5	Partial	Space C, E, & F: Not confidential (3)
RHU GP	IDTT	1	Yes	
	Individual	5	Partial	Overflow D & F: Not at least two chairs (2)
MHCB	IDTT	1	Yes	
	Individual	3	Partial	Room 277: No desk or chairs (1)

"Partial" indicates the space(s) met some but not all audit criteria.

✓ **Strengths**

The RHU CCCMS IDTT space in RHU-1, the ML EOP and MHCB were fully compliant IDTT environments, as they were appropriately sized with a conference table, sufficient seating, adequate ventilation, controlled temperature, and no distracting noises. The RHU CCCMS also has five individual treatment rooms, all well-ventilated and safe, though three lack patient seating and two were adjacent to either a cell or a shower and were not considered fully confidential since other incarcerated individuals can easily overhear the treatment session. The MHCB individual treatment spaces meet audit requirements. The MSF treatment space was fully confidential. Chapels on B, C, and D yards provide confidential, adequate group treatment space.

⚠ **Concerns**

Individual Treatment Spaces: This is driven by three recurring deficiencies. First, ML CCCMS offices in housing units on all yards are sound-confidential but visible from the dayroom, failing the visual confidentiality criterion. Second, several offices are configured with the patient seated between the clinician and the door, creating an egress safety concern. Third, ML EOP offices adjacent to restrooms have sound transfer through ventilation systems. This was also observed in at least two locations in the RHU CCCMS where patients are seen for individual encounters. (See Access to Care: Confidential and Effective Communication for related findings and recommendations on sound masking and visual barriers.)

IDTT Spaces: The low score reflects audit criteria where a room did not have a conference table, and one room where the conference table was not used for its intended purpose. The RHU-1 IDTT space was fully compliant.

Group Treatment Spaces: The space volume deficit in the ML EOP is structural and directly drives the Treatment Offered finding that the program does not schedule enough hours to achieve compliance (see Access to Care: Treatment Offered, Recommendation 1).

Recommendations

1. Develop a Facility-Wide Treatment Space Remediation Plan: The treatment space deficiencies identified in this section are part of a facility-wide pattern documented across multiple domains. Priority Recommendation 2 directs the institution to conduct a comprehensive treatment space assessment

covering all levels of care and program areas, using data collected by the Receiver's Compliance Team during the March 2026 audit as a foundation. The institution should implement remediable improvements identified in this section as immediate actions while the broader assessment is completed. See Priority Recommendation 2 for the full scope.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP).[2] MAPIP tracks the percentage of medication doses provided in a timely manner across all transfer types, administration methods (KOP, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types. It also tracks the required diagnostic monitoring for psychiatric medications. These indicators assess whether patients receive timely access to prescribed medications and whether prescribing practices include appropriate safety monitoring.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non-Adherence Notification (v2.0)	0%†	0%†	18%†	17%†	16%†	18%	14%	
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	37%	28%	28%	28%	17%	10%	26%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								0%

MAPIP Diagnostic Monitoring

Medication Class	Aug	Sep	Oct	Nov	Dec	Jan	6-Mo Avg
Diagnostic Monitoring (All)	80%	84%	82%	81%	83%	79%	82%
Antipsychotics (All)	85%	88%	86%	86%	84%	81%	85%
QT Prolongation EKG	88%	67%	100%	100%	100%	92%	92%
Valproic Acid (All)	75%	68%	70%	70%	87%	77%	74%
Lithium (All)	65%	84%	88%	80%	100%	67%	79%
Oxcarbazepine (All)	64%	72%	83%	66%	81%	67%	72%
Antidepressants (All)	77%	79%	80%	74%	74%	76%	77%
Lamotrigine Consent	—	100%	50%	100%	50%	100%	78%
Carbamazepine (All)	—	—	0%	—	—	100%	57%

Source: Healthcare Services Dashboard / MAPIP.

[2] See Appendix C

✓ **Strengths**

No controlled use-of-force incidents were required to administer PC2602 medication during the reporting period. The Medication Court Administrator reported that PC2602 case management was workable due to active coordination among psychiatrists, patients, and legal representatives for timely petition processing.

QT Prolongation EKG monitoring averaged 92% (green range). Antipsychotic monitoring for blood pressure (99%), height (95%), and weight (98%) was consistently strong, indicating that vital sign and anthropometric monitoring processes are functioning well. Overall diagnostic monitoring composite averaged 82%, in the yellow range.

⚠ **Concerns**

Medication non-adherence response rates are critically low: Timely response to critical medication non-adherence notifications averaged 14% over six months, meaning that patients identified as non-adherent with critical medications received a timely follow-up response in fewer than one of seven cases. Response to non-critical non-adherence averaged 26% and declined from 34% to 10% over the reporting period, a worsening trajectory. These rates indicate a systemic breakdown in the notification-response workflow. Missing orders and incomplete documentation in patient records were identified during the review. Staff Psychiatrist positions were filled at 91% (see Staffing section).

Diagnostic monitoring sub-indicators with sustained deficits:

Sub-Indicator	6-Mo Avg	Pattern
Valproic Acid Level	46%	Ranged 25–75%
Valproic Acid CBC	53%	Ranged 17–86%; erratic month to month
Valproic Acid CMP	51%	Ranged 14–67%
Antidepressant Thyroid (TSH)	53%	Ranged 39–68%;
Antipsychotic Lipid	62%	Ranged 55–73%;
Lithium CMP	64%	Ranged 50–100%;
Antipsychotic Thyroid	73%	Ranged 60–83%;
Antipsychotic Blood Sugar	73%	Ranged 64–82%;

The mood stabilizer monitoring pattern is clinically significant: Valproic acid therapeutic level monitoring averaged 46%. Valproic acid CBC and CMP monitoring, averaged 53% and 51% respectively. CMP monitoring, for patients prescribed lithium, averaged 64%. These medications have narrow therapeutic indices where missed monitoring can result in toxicity, organ damage, or subtherapeutic dosing. Thyroid monitoring for patients prescribed antidepressants averaged 53%, and antipsychotic monitoring (lipids 62%, blood sugar 73%, thyroid 73%) showed sustained deficits. The full MAPIP medication administration breakdown is provided in Appendix C.

Recommendations

1. Conduct a Non-Adherence Notification Response Workflow Review: Map the current workflow for how non-adherence notifications are received, triaged, and scheduled, identifying where notifications are lost, delayed, or not acted upon. Implement revised notification-response procedures with clear assignment of responsibility at each step. Track monthly compliance with a target of sustained improvement toward the compliance threshold.
2. Conduct a Retrospective Review of Mood Stabilizer Diagnostic Monitoring and Implement Prospective Tracking: Conduct a retrospective review of all patients prescribed valproic acid, lithium, carbamazepine, and oxcarbazepine during the reporting period to confirm that required laboratory monitoring has been completed or is now scheduled. Identify the root cause of the monitoring gap (ordering failure, lab completion failure, patient refusal, or documentation error). Implement a

prospective tracking system for mood stabilizer lab monitoring, whether through standing lab order review, automated EHRS reminders, or a manual monitoring calendar. Extend this review to antipsychotic metabolic monitoring measures showing sustained deficits (lipids, blood sugar, thyroid).

3. Provide MAPIP Training on Monitoring Timelines: Distribute written guidance on current MAPIP monitoring requirements, including the updated timelines from the March 2025 memorandum. Conduct a training session for all prescribing staff addressing monitoring timelines, ordering procedures, and documentation requirements. Track completion and assess impact on monitoring compliance.

Patient Safety

Institutions are required to maintain safeguards against heat-related illness for all incarcerated individuals, with additional safeguards for patients prescribed medications that impair thermoregulation and to ensure that any use of clinical restraints or seclusion complies with established protocols. These indicators assess environmental safety monitoring and the quality of restraint and seclusion practices.

Indicator	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0
Clinical Restraint Occurrences Meeting All of the Audit Criteria	0%†
Maximum Number Restraint Incidents	1
Maximum Number of Seclusion Incidents	2
Restraint Duration Incidents Greater than 4 Hours	0%†
Restraint Incidents	4
Seclusion Duration Incidents greater than 8 Hours	25%†
Seclusion Incidents	4

✓ **Strengths**

Heat Plan compliance has improved since the last review. No heat-related illness incidents occurred among MHSDS patients prescribed heat alert medications during the reporting period. No Stage II or Stage III heat events required precautionary activation. The onsite audit confirmed that the facility's heat plan is current, working thermometers were placed in appropriate locations across housing units, and heat logs were being maintained with the highest temperature recorded. Staff demonstrated adequate knowledge of heat protocols.

The Chief Nurse Executive provided evidence during the onsite visit that corrective actions had been initiated in response to restraint and seclusion documentation deficiencies, including targeted training for staff on restraint management and documentation practices.

⚠ **Concerns**

Five-point restraint documentation was deficient in every case reviewed: Five-point restraint episodes were logged during the reporting period, generating four restraint checklists (one entry was documented in error). None of the checklists met audit criteria. In several cases, monitoring records extended after the orders expired, and none of the cases provided adequate documentation of efforts to prevent restraint. There was no indication that less restrictive interventions were considered or attempted prior to resorting to five-point restraints. Furthermore, the rationale for applying the fifth restraint was not clearly documented or verified by a provider or registered nurse, and critical electronic health record fields for confirming range-of-motion were incomplete. Seclusion documentation showed multiple deficiencies across all four episodes: In one case, a Registered Nurse documented that a patient was placed in seclusion due to a "lack of available MHCBs" rather than for clinical justification. Bed unavailability is not an appropriate clinical basis for seclusion. Multiple seclusion initiation and continuation orders were placed for one patient on the same date, and monitoring documentation showed seclusion continuing during a period when the seclusion order was not active. Hydration and nourishment monitoring was inconsistent, and some episodes exceeded authorized durations.

Recommendations

1. Implement Real-Time Documentation Audits During Restraint and Seclusion Events: Develop and distribute a restraint/seclusion documentation checklist aligned with audit criteria (including verification of less restrictive alternatives attempted, justification, range-of-motion documentation, soft cloth bandage application, and order-to-monitoring time alignment). Present restraint and seclusion audit results, conducted by local designee (SRNII or Lead RN), monthly in the Mental Health Program Sub-Committee (MHPSC). Ensure all future restraint events include documented consideration of less restrictive alternatives prior to application of five-point restraints.
2. Ensure Seclusion Reflects Clinical Justification and Complies with Time Limits: Review all seclusion orders from the reporting period to identify whether additional instances of non-clinical justification exist. Provide training to nursing and clinical staff on seclusion documentation requirements, including order renewal procedures, duration limits, and hydration/nourishment monitoring requirements.

Quality of Care: Care Access

Interdisciplinary Treatment Team (IDTT) meetings must include all required staff, follow an interactive and collaborative process, and address key clinical elements including case formulation, measurable treatment goals, and discussions involving the appropriateness of the patient's level-of-care. These indicators assess both the structure and quality of the primary clinical processes through which treatment is planned and delivered.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	35%	31%	28%	33%	28%	31%	31%	
IDTT Required Staffing	39%	52%	47%	46%	42%	38%	44%	
IDTTs with Observed Interactive Process								29%

✓ **Strengths**

Electronic Health Records System (EHRS) and Strategic Offender Management System (SOMS) were available in 100% of observed IDTTs. The GP RHU IDTT met most audit criteria, and the RHU CCCMS IDTT space was appropriately equipped for the team discussion. Patient attendance at IDTTs was not identified as a barrier; patients generally attended when scheduled, though several reported being dissatisfied with the process once they arrived.

⚠ **Concerns**

IDTT Required Staffing averaged 44% with no improvement trend: More than half of IDTTs during the reporting period did not have all required attendees. The rate ranged from 38% to 52% with no directional movement, indicating a stable deficit rather than a deteriorating or improving one. The staffing data in this report shows Staff Psychiatrist fill at 91% and MHPC fill at 75% (including telehealth) This suggests that there is adequate clinical staffing for IDTTs. However, required clinical staff are not attending IDTTs when their patient is appearing before the treatment team.

Only 29% of observed IDTTs met the interactive process standard: The onsite audit team observed IDTTs across multiple programs and found that in the ML EOP, most elements audited by CQIT were either absent or not adequately addressed. Specific deficiencies included: the purpose of the IDTT was not stated in one case; case presentations provided brief clinical summaries but lacked essential case formulation elements (functional impairments, current diagnosis, areas of distress, patient strengths); measurable treatment goals were

reviewed in only one of five observed cases, with three having vague general goals and one having none; treatment progress toward prior goals was not assessed; and level-of-care decisions were either missing or lacked clinical rationale.

Patients confirmed these findings. None of the eight RHU CCCMS patients interviewed knew or understood their treatment plan. Most ML CCCMS patients were similarly unaware of their treatment plans or the purpose of IDTTs. Patients across programs expressed general dissatisfaction with IDTTs, describing them as brief, formulaic, and not responsive to their concerns.

Recommendations

1. Implement a Structured IDTT Quality Improvement Initiative: Begin supervisory observation of IDTTs using the checklist, with direct feedback to the treatment team after each observation. Provide training on case formulation and treatment goal development for all clinical staff, with emphasis on linking treatment goals to diagnosis and functional impairments.

Quality of Care: Documentation

The Program Guide requires that clinical documentation reflect individualized treatment planning, timely completion of intake evaluations prior to the initial IDTT, appropriate consideration and documentation of higher-level-of-care (HLOC) need, pre-release planning, and accommodation assessment for EOP patients. These indicators assess whether the clinical record supports the treatment decisions being made for each patient.

Indicator	Onsite Audits
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC	71%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education	0%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT	100%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT	63%†

✓ **Strengths**

Primary clinician intake evaluations were completed prior to the initial IDTT in 100% of cases reviewed, though the sample was small. This indicates that the workflow for ensuring a PC evaluation precedes the first treatment planning meeting is functioning for the cases assessed.

⚠ **Concerns**

Psychiatry intake evaluations: In more than a third of cases reviewed, the initial treatment planning meeting occurred without input from the assigned psychiatrist. The Sustainable Process Addendum confirmed that initial IDTTs were being held in RHU CCCMS before initial MHMD contacts were completed, meaning the treatment team was making level-of-care and treatment decisions without a psychiatric evaluation. This deficit is related to the MHMD scheduling workflow concerns discussed in Access to Care: Timely Access.

EOP IDTTs addressing clinical appropriateness for work and education assignments were at 0%: While based on a small sample, this indicates that the work/education accommodation discussion required by the Program Guide is not occurring in EOP IDTTs at KVSP. For patients whose mental health conditions affect their capacity to participate in institutional programming, this assessment is a prerequisite for appropriate assignment to rehabilitative programming.

Recommendations

1. Implement HLOC Documentation Corrective Actions from the Sustainable Process Addendum: Implement the specific action items from the Sustainable Process Addendum, including supervisory review of HLOC forms on the day of IDTT. Conduct a targeted self-audit of 20 HLOC non-referral cases to assess whether the corrective actions are producing improvement.
2. Ensure All EOP IDTTs Include a Work and Education Accommodation Discussion: Incorporate accommodation and clinical appropriateness for work/education assignments in all Initial EOP IDTTs. Include this element in the IDTT checklist developed under Quality of Care: Care Access, Recommendation 1. Conduct supervisory observation of a sample of Initial EOP IDTTs to verify that the discussion is occurring and documented.

Rules Violation Reports

The Program Guide requires that when MHSDS patients receive a Rules Violation Report (RVR), a mental health assessment (RVR-MHA) is conducted to evaluate whether the patient's mental health condition contributed to the behavior underlying the violation. The RVR-MHA serves two critical functions: informing the disciplinary hearing officer about mental health factors that may warrant alternative discipline or mitigation of penalties, and protecting patients whose rule-violating behavior may be symptomatic of their mental disorder from disproportionate consequences. These indicators track the timeliness of the process (custody's submission of the MHA request and clinician's completion of the assessment), the conditions under which assessments are conducted (private setting, confidentiality advisement), and the quality of the resulting documentation.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	33%	24%	43%	26%	27%	26%	30%	
RVR MH Assessments where Documentation Requirements were Met			100%†	100%†	94%†	0%†	72%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality			100%†	100%†	100%†	100%†	100%	
Timely RVR MH Assessment Request	28%	44%	51%	43%	53%	61%	48%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	84%	92%	96%	83%	65%	20%	72%	
RVR's Issued								4,443
RVR's Issued to Non-MHSDS Participants								33%
RVR's Issued to Patients at the Acute Level of Care								0%
RVR's Issued to Patients at the CCCMS Level of Care								50%
RVR's Issued to Patients at the EOP Level of Care								15%
RVR's Issued to Patients at the ICF Level of Care								0%
RVR's Issued to Patients at the MHCB Level of Care								2%

✓ **Strengths**

Patients were informed of the limits of confidentiality in 100% of assessed cases. Timely RVR MH Assessment Requests trended upward, improving from 28% in August to 61% in January. This sustained improvement suggests that corrective measures applied to the request process during the reporting period are taking hold.

⚠ **Concerns**

Timely submission of completed MH assessment results declined sharply in January: It declined from 96% in October to 20% in January. The six-month average of 72% masks a trajectory that is worsening rapidly. At 20%, four of five completed assessments in January were not submitted within required timeframes. This decline occurred during the same period that assessment requests were improving (Timely RVR MH Assessment Request rising to 61%), which suggests the bottleneck shifted from the front end (requesting the assessment) to the back end (completing and returning it). The root cause, whether clinician workload, workflow confusion, competing clinical demands, or administrative barriers, requires investigation.

RVR MH Assessments were conducted in a private setting only 30% of the time: This rate was stable across all six months (range: 24–43%), indicating a persistent barrier rather than a temporary condition. Seven of ten assessments occurred in settings that did not provide patient privacy. Given that the assessment requires the clinician to evaluate the role of mental illness in the patient's behavior and discuss potential sanction mitigation, the absence of confidentiality may affect both the quality of the assessment and the patient's willingness to disclose clinically relevant information. Clinicians onsite reported a high rate of patients refusing the RVR-MHA in confidential locations, often expressing disinterest in participating.

Assessment request timeliness, while improving, remains in the red range. At 48%, fewer than half of RVR MH assessment requests were submitted timely during the reporting period. The upward trend from 28% to 66% is meaningful, but the indicator has not yet reached the compliance threshold. The improvement trajectory suggests the current corrective approach is working and should be sustained rather than replaced.

RVR volume at KVSP is substantial. At 4,443 RVRs over six months (approximately 714 per month), the volume of assessments required places significant demands on clinical staff time. Approximately 67% of RVRs were issued to MHSDS patients (EOP, CCCMS, and MHCB combined), many requiring a mental health assessment.

Recommendations

1. Investigate and Reverse the decline in RVR-MHA timely assessment results: Identify the specific bottleneck in the assessment completion and submission workflow (e.g., whether the barrier is clinician assignment, turnaround time expectations, competing clinical demands, or an administrative processing failure). Implement corrective measures targeting the identified barrier. Track progress monthly and report results in the MHPSC.
2. Identify and Address the Barrier to Confidential RVR MH Assessments: Conduct a review of where and how RVR MH assessments are currently being completed, identifying what proportion occur at cell front, in hearing rooms, or in treatment spaces. Determine whether the barrier is patient refusal, space availability or location, custody-imposed restrictions on patient movement, or scheduling practices.
3. Sustain the Assessment Request Timeliness Improvement: Document the specific changes that produced this improvement so they can be sustained and reinforced. Continue monthly tracking in the MHPSC.

RHU: Timeliness

Patients placed in Restricted Housing Units (RHU) must receive timely transfers to appropriate mental health housing designations and Institution Classification Committee (ICC) hearings must be conducted within required timeframes with meaningful mental health participation. Mental health clinician presence at ICCs ensures that clinical needs are considered alongside custody factors, and the provision of relevant clinical

information enables the committee to make informed placement decisions that account for the patient's mental health status.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
Timely Transfers to RHU EOP	21%	53%†	37%	24%	48%	28%	33%	
Required NDRH Transfers that Occurred Within 72 Hours								0%†

✓ **Strengths**

Non-Disciplinary Restricted Housing (NDRH) tracking procedures met compliance standards during the onsite review. Property issuance logs and NDRH tracking logs were current and accurate. Patients identified as NDRH-designated had current documentation supporting their housing status. These custodial monitoring processes provide the administrative foundation for ensuring NDRH patients are identified and tracked for timely transfer.

⚠ **Concerns**

Timely Transfers to RHU EOP averaged 33% over six months: The monthly data shows no improvement trend; the rate oscillated between 21% and 53% with no sustained direction. The primary driver is the statewide RHU EOP bed shortage: KVSP does not have a designated RHU EOP program and must transfer patients to hub institutions. Transfer timeliness depends on bed availability at receiving facilities, which is outside KVSP's institutional control.

While awaiting transfer, these patients remain in settings that have already been determined to be clinically inadequate for their level of care. The Timely Access and Treatment Offered sections of this report document that RHU EOP overflow patients received 0% of required structured treatment during the reporting period. The transfer delay directly affects patient access to the treatment program that was clinically indicated.

Required NDRH Transfers Within 72 Hours[3]: Based on a small sample, no NDRH-designated patients transferred within 72 hours of ICC approval. NDRH tracking and documentation procedures were compliant during the onsite review, indicating that the identification and tracking process is functioning, but the timely transfer execution is not.

Recommendations

1. Some of the deficiencies identified in this section are driven in part by the statewide shortage of designated beds, which is outside institutional control. The institution cannot transfer patients to beds that do not exist. However, the institution is responsible for ensuring that patients awaiting transfer receive treatment services available in their current setting, that pending transfers are tracked and prioritized by clinical acuity, and that cases involving clinical deterioration are escalated immediately through the Regional Mental Health Administrator. The Receiver recognizes that the systemwide shortage of designated beds at the required levels of care is a structural barrier affecting multiple institutions and will address it as part of her broader remedial planning, including evaluation of bed capacity, population distribution, and institution resources.

RHU: Documentation

Psychiatric Technician (PT) rounds in Restricted Housing Units must be completed daily with appropriate documentation, interactions with patients must meet standards for effective communication and clinical

[3] Current CQIT auditor instructions were flagged by the RCT as potentially unclear and contributing to inconsistent results. This item has been flagged for review with the Receiver's team.

referral, and treatment team members must have access to and actively review electronic records during IDTTs. PT rounds serve as the primary daily mental health monitoring function in RHU, where patients have limited contact with other clinical staff between scheduled appointments. These indicators assess whether rounds are being completed, whether the quality of interactions meets clinical standards, and whether documentation accurately captures the encounter.

Indicator	Oct 2025	Nov 2025	Dec 2025	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	0%†	100%†	100%†	40%†	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available					100%
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria					100%†
Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria					100%†
PT Rounds Completed in Restricted Housing Units					100%†

✓ **Strengths**

PT rounds were conducted in all three locations housing RHU-designated individuals (RHU-1, RHU-2, and B1 overflow). Staff demonstrated commitment to patient engagement: mental health screening questions were asked as written, clarified when needed, and staff interacted with patients directly rather than through proxies. In B1 overflow, the PT offered forms and puzzles to patients during rounds. Documentation was completed in real time at cell front, promoting accuracy. The audit team described B1 overflow PT rounds as excellent.

⚠ **Concerns**

Security welfare checks: Guard One electronic tracking showed 91% compliance in RHU-1 and 88% in RHU-2 for February 2026. These rates meet or approach the compliance threshold for the electronic log. However, onsite observation revealed that the quality of the checks themselves was deficient across all RHU settings. Staff were observed completing welfare checks through partially covered cell windows and blacked-out cells and accepting verbal confirmations of wellbeing rather than directly observing everyone.

B1 overflow, which does not have Guard One capability, relies on manual tracking sheets. These sheets were reviewed and found up to date.

Intake cell capacity: Three individuals in RHU-1 remained in intake cells beyond 72 hours because all non-intake cells were occupied, preventing transfer. One individual in the GP RHU who required an intake cell was inappropriately housed because all intake cells were occupied. (This finding is noted for context; the intake cell concern is addressed in the Suicide Prevention section as it relates to suicide-resistant housing requirements.)

Recommendations

1. Retrain All RHU Staff on Security Welfare Check Requirements and Initiate Supervisory Audits: Conduct retraining for all custody staff assigned to RHU-1, RHU-2, and B1 overflow on welfare check requirements, with emphasis on three standards: (1) each check requires direct visual confirmation of a living, breathing individual free from obvious injury; (2) verbal confirmation from a cell occupant does not satisfy this requirement; (3) cell windows must not be covered, taped, or obstructed in a manner that prevents visual observation. Initiate weekly supervisory audits of welfare check quality (not just timing) across all RHU settings, including B1 overflow.
2. Ensure RHU Preplacement Screenings Are Conducted Electronically and Confidentially: The Facility C gym screening observed during the audit required paper forms due to connectivity issues and initially lacked auditory privacy. Assess connectivity in all locations where preplacement screenings are conducted and resolve technical barriers to electronic documentation.

RHU: Out-of-Cell Activities/Care

The Program Guide requires that patients in restricted housing receive out-of-cell time, shower access, phone access, entertainment appliances, personal property, and orientation materials. These indicators assess whether the custodial functions that support daily living and treatment access in the RHU are functioning.

Additionally, custody staff in Restricted Housing Units should be able to identify all Non-Disciplinary Restricted Housing (NDRH) patients and know that NDRH patients receive specific protection including access to personal property, entertainment appliances, telephone calls, and timely transfers when eligible.

Indicator	Onsite Audits
Custody Staff who can Identify all NDRH Patients	100%†
NDRH Patients Provided Personal Property	90%
Patients in restricted housing with working entertainment appliances	100%
Peace Officers Observed to Carry Their CPR Mouth Shield	100%
RHU CCCMS Out of Cell Time Offered	100%
RHU Shower Access	100%

✓ **Strengths**

Custodial care functions in designated RHU programs are largely compliant. ARHR data for designated RHU CCCMS and RHU GP patients confirmed that out-of-cell time, shower access, and phone access met requirements. All patients observed in the RHU CCCMS and GP RHU, including B1 overflow, were in possession of working entertainment appliances. NDRH patients had been provided with personal property in 90% of cases. All peace officers observed in restricted housing were carrying CPR mouth shields. Custody staff could identify all NDRH patients (100%). These findings indicate that the custodial infrastructure supporting daily living in designated RHU settings is functioning. Staff demonstrated awareness of their responsibilities for patient property, appliance access, and emergency preparedness.

⚠ **Concerns**

Group Treatment: Overflow populations are not receiving group treatment, and most are not receiving confidential individual encounters. Patients in RHU EOP overflow and RHU CCCMS overflow were offered 0% of required out-of-cell structured treatment during the reporting period (see Access to Care: Treatment Offered).

Only CCCMS patients in the GP RHU are receiving confidential individual encounters. B1 overflow has four non-confidential treatment modules, and most clinical encounters in that setting occur at cell front. This means patients in overflow settings are receiving custodial out-of-cell activities (yard, shower, phone) but not the clinical programming their level of care requires.

Jumpsuit shortages: The insufficient supply of jumpsuits continues to prevent patients from leaving cells. As discussed in Access to Care: Timely Access, jumpsuit shortages in the RHU have persisted for approximately one year and are an ongoing barrier to both treatment access and out-of-cell activities. Paper jumpsuits have been used as an interim measure for some patients. This barrier affects custodial out-of-cell activities as well as clinical contacts.

Recommendations

1. Develop a Plan to Provide Structured Treatment to Overflow Populations: The treatment space deficiencies identified in this section are part of a facility-wide pattern documented across multiple domains. Priority Recommendation 2 directs the institution to conduct a comprehensive treatment space assessment covering all levels of care and program areas, using data collected by the Receiver's Compliance Team during the March 2026 audit as a foundation. The institution should implement remediable improvements identified in this section as immediate actions while the broader assessment is completed. See Priority Recommendation 2 for the full scope.

Sentinel Events and Specialized Custody

This section presents sentinel event data (deaths, self-harm, and serious incidents) alongside specialized custody indicators that assess use-of-force training, heat plan compliance, mechanical restraint documentation, and mental health participation in use-of-force events. These indicators measure whether the institution's custody infrastructure supports the safety of patients with serious mental disorders, both through emergency preparedness and through the systems designed to prevent harm.

Indicator	On-site Audits
Custody Staff Attendance at UOF Training	100%
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated	N/A
MHCB Patients Placed in TTM According to Policy	N/A
The Use and Documentation of Mechanical Restraints Among Non-MAX Custody Patients in MHCB Units	0%†
Thermometer Checks completed and accurate	100%
Use of Force Involving MH Patients	89%

✓ **Strengths**

Custody staff completed Use of Force training at 100%. Thermometer checks were completed and accurate in all housing units reviewed (100%). Heat logs were maintained with the highest temperature recorded. No heat-related illness incidents occurred among MHSDS patients during the reporting period. The Heat Plan was not activated (no Stage II or III events), but staff demonstrated adequate knowledge of heat protocols. Heat Plan compliance has improved since the last full review.

128B Mechanical Restraint Reviews were posted on all MHCB cell doors (100%). There was no use of mechanical restraints among non-MAX custody MHCB patients during the reporting period. These findings

indicate that the MHCB is maintaining appropriate restraint documentation and that mechanical restraints are not being applied to patients whose custody classification does not warrant them.

⚠ Concerns

Heat plan temperature logs showed discrepancies in Central Control's outdoor records for August and September 2025: Monthly Summary Reports reflected inconsistencies in outdoor temperature documentation during the two hottest months of the reporting period. While the overall Heat Plan was assessed as compliant and has improved since the prior review, temperature documentation accuracy during peak-risk months is essential for activating the correct stage response. The discrepancy should be investigated to determine whether it reflects a documentation error or an actual gap in monitoring.

Recommendations

1. Investigate and Correct the Heat Plan Temperature Log Discrepancies: Review Central Control's outdoor temperature records for August and September 2025 to determine whether the discrepancies in the Monthly Summary Reports reflect documentation errors, equipment malfunction, or incomplete monitoring. Ensure that the temperature recording process for outdoor readings is documented in a post order or standard operating procedure and that staff are trained in accurate recording. Verify compliance during the next heat season.

Suicide Prevention

The Program Guide establishes clinical requirements for suicide risk evaluation, safety planning, crisis bed management, post-discharge follow-up, welfare checks, and staff training. These indicators assess whether the institution's suicide prevention processes (from initial risk identification through crisis stabilization and return to the general population) function as intended. Detailed findings from the Receiver's Compliance Team and Regional SPRFIT Review are attached as Appendix B.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
Discharges from MHCB with clinician review of d/c summary				0%†	0%†	100%†	38%†	
Documentation of Acute/ICF Discharges with Clinician-to-Clinician Contact within 5 days	100%†	100%†	100%†	100%†	100%†		100%†	
Emergent and Urgent MH Referrals That Result in SREs	96%	99%	96%	97%	97%	97%	97%	
MHCB Daily Provider Contacts (v2.0)	60%	74%	67%	67%	76%	71%	69%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	0%†	0%†	54%†	29%	61%†	100%	44%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training		73%			53%	93%	72%	
Safety Plans Signed Timely	94%	86%	91%	87%	85%	90%	89%	
Timely Clinical Follow-Ups (V2.0)	70%	65%	65%	68%	32%	15%	53%	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation								83%

Custody Follow Ups, Page 1								77%
Custody Follow Ups, Page 2								59%
Custody Staff with CPR Training								99%
Healthcare staff current with suicide prevention training								98%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								95%
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								0%†
MHCB and Acute/ICF Out of Cell Activities - Dayroom								100%†
MHCB and Acute/ICF Out of Cell Activities – Phone Calls								100%†
MHCB and Acute/ICF Out of Cell Activities - Showers								100%†
MHCB and Acute/ICF Out of Cell Activities - Yard								100%†
MHCB and Acute/ICF Records with Rationale for Partial Issue								38%†
MHCB Out of Cell Activities								33%†
Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								100%†
Onsite Review of Patient Orders for Issue and Observation								100%†
Patients in Alternative Housing with a Bed								100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral								80%†
RHU Intake Incarcerated Persons Appropriately Housed								50%†
Suicide Resistant Cells								100%†

✓ **Strengths**

Training compliance is strong across all disciplines. Custody suicide prevention training (100%), nursing CPR (100%), healthcare staff suicide prevention training (100%), and custody CPR (99%) all meet or exceed thresholds. SRE mentoring improved from 76.4% to 83% over the reporting period, approaching the 90% target. Biennial SRE training (94%), Safety Planning training (90%), SRMP training (96%), and Complex Cases training (98%) all exceeded compliance thresholds.

Emergency preparedness infrastructure is compliant. All housing units reviewed had compliant cut-down kits with standardized inventory sheets. All MHCB cells, B1 overflow cells (with two DPW exceptions), and RHU intake cells met suicide-resistant criteria. Five GP RHU cells missing intake placards were corrected onsite during the audit.

Emergent and urgent referrals resulted in SREs 97% of the time. SREs upon rescission of MHCB referrals were completed 98% of the time. Suicide precaution rounds were timely at 97% with 100% staggard observation compliance. R&R initial health screenings met all audit requirements.

Alternative housing patients observed during the onsite review were appropriately managed. All three patients were on suicide watch with nursing staff maintaining direct visual observation and recording observations in EHRS in real time. One patient had been evaluated the previous night and was waiting for MHCB placement. The other two were offered confidential evaluations.

⚠ Concerns

SRE Quality and Documentation: Overall SRE compliance declined from 95% to 73%, driven by specific sub-indicators. Compliance for SREs upon MHCB referral for Danger to Self (DTS) was 53%, down from 99%, and compliance for post-discharge follow-up SREs at 30 days was 8%.

SRE Compliance by Type	Compliance	N
Emergent consults for DTS	98%	857
Upon rescission of MHCB referral	98%	—
Upon MHCB referral for DTS	53%	—
30-day post-MHCB SRE	8%	36
Overall SRE Compliance	73%	1,539

The 53% rate for SREs upon MHCB referral for DTS represents the most significant decline in any single SRE sub-indicator. In several cases, clinicians used an SRE Reassessment form rather than the required full SRE, which does not meet the audit standard.

Onsite observation revealed clinical process failures. During the audit, two alternative housing assessments were observed. In both cases, the clinician did not ask about current suicidal ideation or intent. Documentation from the subsequently completed SREs was inconsistent with what auditors observed (denial of suicidal ideation was documented despite the topic not being raised during the clinical encounter).

Urgent and Emergent Referrals: Review of a sample of 15 urgent and emergent referrals that were not placed for DTS but requiring SREs found that of the fifteen cases reviewed, only twelve (80%) had completed the required SRE. In several cases reviewed, the abbreviated SRE reassessment form was incorrectly utilized in lieu of the full form.

Safety Planning Quality: Safety plan quality is the subject of one open HQ SPRFIT corrective action plan and one new HQ CAP. Of fifteen safety plans reviewed for rescinded MHCB referrals, fourteen were not individualized to the patient's specific risk factors and relied on stock phrasing with nearly identical interventions. None were completed collaboratively with patients (all fifteen were completed without patient participation).

Of five discharge safety plans reviewed, two were clinically insufficient. Supervisory review of discharge safety plans was completed timely for only 42% of MHCB discharges (N=44 of 105 discharges for DTS). August and September showed 0% supervisory review compliance; January recovered to 100%.

MHCB Issue and Observation Order Documentation: Of eight MHCB patients reviewed for daily justification of issue and observation orders during suicide precaution status, only one had adequate documentation for all days. Clinically insufficient documents either failed to address issue and observation orders altogether or noted status without providing justification for the specific level ordered. This documentation is the clinical rationale for why a patient remains on a particular level of restriction. Without daily justification, there is no clinical record supporting the decision to maintain or modify observation status.

Timely Clinical Follow-Ups[4]: Timely clinical follow-ups declined from 70% to 15% over the reporting period. The low rates of timely follow ups in December–January (32% and 15%) warrant immediate investigation.

Custody Inpatient Discharge Follow-Ups (7497s): Of the 58 forms reviewed through CQIT, 30 (52%) contained no errors. Nineteen had missed supervisory reviews, thirteen had missed custody checks, nine were missing arrival information, and four had pre-filled information on the custody checks portion.

SPRFIT Committee: Minutes for August 2025 through January 2026 were reviewed. Quorums were met for all meetings. The SPRFIT template incorrectly lists the senior psychologist supervisor as an authorized designee for the chief psychiatrist; only a psychiatrist may serve as designee. Clinical summaries of serious suicide attempts were mentioned in September and January minutes but without proof of practice attached. August through October minutes listed Suicide Risk Management Plan (SRMP) patient totals without presenting tracking or review data.

Recommendations

1. Provide Refresher Safety Planning Training and Initiate Monthly Supervisory Review: Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to emergent referrals and MHCB discharges. Emphasize that safety plans must reflect the patient's specific risk factors, be developed collaboratively with the patient, and not consist of stock phrasing. Initiate monthly supervisory review of a random sample of ten safety plans for rescinded MHCB referrals, with individual mentoring for plans that do not meet standards. Resolve open HQ SPRFIT CAPs within established deadlines.
2. Ensure Daily Provider Documentation in the MHCB Justifies Issue and Observation Orders: Establish a daily supervisory review process focusing on the justifications for daily observation orders and provide real-time training to clinicians whose documentation does not meet standards.
3. Provide Refresher SRE Training Emphasizing Direct Inquiry and Documentation Accuracy: The onsite observation of clinicians not asking about suicidal ideation during crisis evaluations, followed by documentation that the patient denied ideation, is a patient safety and documentation integrity concern. Provide refresher SRE training to all clinical staff emphasizing that direct inquiry about current suicidal ideation and intent is required in every SRE, and that documentation must reflect only what was observed and communicated during the evaluation. Ensure clinicians understand that the full SRE form (not the Reassessment form) is required for MHCB referrals. Conduct supervisory observations of SREs to verify compliance.
4. Investigate and Reverse the Timely Clinical Follow-Up Decline: The compliance rate decline from 70% to 15% over the reporting period should be reviewed. Identify the specific barrier that produced the December–January decline (scheduling failure, staffing gap, workflow change, or documentation error). Implement corrective measures and begin tracking weekly follow-up completion rates.
5. Develop a Plan to Increase MHCB Out-of-Cell Activity Hours to Meet the Minimum Standard: Review the MHCB daily schedule to identify barriers to achieving ten hours (staffing, space, custody coordination, patient refusal patterns). Implement scheduling changes and track average weekly out-of-cell hours per patient weekly.
6. Improve Custody Inpatient Discharge Follow-Ups Completion and Accuracy: Provide targeted retraining on completion for custody, emphasizing the specific error categories identified (missed supervisory reviews, missed custody checks, missing arrival information, pre-filled entries). Direct supervisory staff

[4] Percentage of clinical follow-up sequences completed on time after physical discharge from an Acute program, ICF program, or DSH location, or physical discharge from a MHCB program for patients referred for suicidality, or after a rescinded MHCB referral for suicidality.

to review for completeness prior to filing. Conduct a self-audit of a sample of 20 discharge follow-ups using the CQIT review criteria to assess whether the retraining has produced measurable improvement.

Sustainable Process and Utilization Review

Sustainable process reviews assess whether clinical documentation practices and level-of-care decisions meet Program Guide standards on a sustained basis, not just during audit visits. These indicators are drawn from quarterly HQ reviews, Inpatient Coordinator (IPC) audits, and the automated monitoring of MHCB utilization.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg
MHCB clinical stays within timeframes	77%	63%	76%†	83%	92%	92%	81%
Timely Transfer to MHCB (v2.0)	92%	92%	92%	88%†	80%†	92%†	90%

✓ **Strengths**

Timely Transfer to MHCB averaged 90% (green range). The MHCB admission process functions efficiently despite KVSP's 12-bed capacity and high referral volume. (See Access to Care: Timely Transfers for full discussion.)

⚠ **Concerns**

PIP referral processing has declined across the last two consecutive quarters: KVSP failed to meet referral timelines in seven of twenty referrals. Similarly, sixteen of the twenty PIP referrals across Q4 2025 and Q1 2026 were transferred within required timeframes, with four transferring past the acceptable timeframe. The referral-to-transfer pipeline for patients requiring inpatient care is not functioning as required.

HLOC non-referral documentation has declined for five consecutive quarters: The HQ review found 27% compliance for Q1 2026 (10 of 37 cases). The Inpatient Coordinator's (IPC) audit of the same 37 cases yielded 70% (26 of 37). The 43% disagreement rate between HQ and the IPC on the same case sample indicates that the two reviewing bodies are applying different standards. The five-quarter decline demonstrates that corrective actions implemented over the past year have not been effective. Each quarter, the institution has been directed to improve HLOC documentation; each quarter, performance has worsened.

Compliance with contacts and documentation for patients returning from PIP declined from Q4 2025 to Q1 2026: Patients returning from inpatient psychiatric care are in a clinically vulnerable transition period. Ensuring timely contacts and adequate documentation upon return is essential for care continuity and for monitoring the effectiveness of the inpatient intervention.

Initial IDTTs in the RHU CCCMS were held before initial MHMD contacts were completed: This means treatment teams were making level-of-care and treatment planning decisions without the psychiatric evaluation that is required to precede the initial IDTT. The Addendum identifies this as a finding across the reporting period. This concern is also reflected in the QC7 indicator (Psychiatry Intake Completed Prior to Initial IDTT: 63%) discussed in Quality of Care: Documentation.

MHCB overstay documentation for safety-related delays requires improvement: The Addendum notes that documentation for MHCB overstays attributed to safety concerns can be improved by clearly articulating the communication between mental health and custody to ensure patients are moved timely. When an MHCB stay extends beyond clinical timeframes due to custody safety concerns (e.g., bed unavailability at the receiving unit, or transport delays), the clinical record should document the specific safety concern, the communication between disciplines, and the expected timeline for resolution.

Recommendations

1. Ensure Timely Contacts and Documentation for Patients Returning from PIP: Review the specific contact and documentation requirements for PIP returns and identify the barriers that caused the Q4-to-Q1 compliance decline. The CMH should develop a system to identify and track all patients returning from a PIP and ensure that all required contacts and services are completed within the mandated timeframes. The results of these efforts should be reported on at least monthly in the MHPSC meeting until sustained compliant performance is observed on all measures.
2. Improve Documentation of MHCB Overstays Attributed to Safety Concerns: Adhere to established policy on addressing MHCB overstays that result in ten-day extensions due to safety concern disclosures and ensure that communication between mental health and custody regarding the delay, and the expected resolution timeline is clearly included in all corresponding documentation. Review a sample of overstay cases to verify the standard is being applied and report on these findings in the MHPSC meeting on an at least once a month basis.

Staffing

Adequate staffing is critical to compliance with many audit requirements in this report. Timely contacts, IDTT quality, treatment hours, supervisory oversight, and suicide prevention all depend on having enough qualified clinicians available to deliver services. The table includes the allocated and filled positions by classification for the reporting period, with functional vacancy rates reflecting weighted averages across months. Allocations for several classifications changed in January 2026 in response to staffing revisions.

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2.0	2.0	0%
Chief Psychiatrist	1.0	1.0	0%
Senior Psychiatrist (Supervisor)	1.0	0.0	100%
Senior Psychologist (Supervisor)	4.2*	2.0	52%
Supervising Psychiatric Social Worker I	1.0	1.0	0%
Senior Psychologist (Specialist)	5.0	4.0	20%
Recreation Therapist	11.2*	8.5	24%
Staff Psychiatrist	10.4*	9.5	9%
Psychologist – Clinical	7.0	7.0	0%
Clinical Social Worker	2.0	2.0	0%
Primary Clinician (PC)	38.4	28.8	25%
PC: Psychologist – Clinical		10.7	
PC: Clinical Social Worker		12.2	
PC: Marriage and Family Therapist		3.5	
PC: Professional Clinical Counselor		2.3	

Allocation changed during the reporting period due to January 2026 staffing revisions (*). Vacancy rates are weighted averages. Filled positions for Primary Clinician sub-classifications show the discipline breakdown of the 28.8 filled PC positions. Telehealth and registry providers are included.

✓ **Strengths**

Both Chief Psychologist positions, the Chief Psychiatrist position, and the Supervising Psychiatric Social Worker I position were filled during the reporting period. This provides a foundational institution leadership infrastructure necessary to implement corrective actions and oversee many but not all program operations.

Staff Psychiatrist positions averaged a 91% fill rate. The allocation increased during the reporting period following the January 2026 staffing revision. Eleven onsite clinicians were hired during the past six months. The addition of six medical assistants to support telehealth providers, and ongoing efforts by the Regional Hiring Unit (RHU) demonstrates that active recruitment efforts are in effect. KVSP has implemented internship and practicum programs to build a recruitment pipeline

⚠ **Concerns**

The Senior Psychiatrist (Supervisor) position was vacant for the full reporting period: This position provides clinical oversight for the psychiatric team. The absence means the Chief Psychiatrist is the sole supervisory authority for all psychiatric staff, which limits the capacity for direct clinical supervision, chart review, and quality monitoring of psychiatric care, functions that are relevant to the MAPIP monitoring deficits and non-adherence notification failures documented in the Psychiatry section.

Senior Psychologist (Supervisor) positions were filled at 48%: With only two of approximately four supervisory positions filled, supervisory capacity for the clinical psychology staff is significantly constrained. This contributes to the IDTT quality deficits documented in Quality of Care: Care Access (44% required staffing, 29% interactive process) and the limited supervisory clinical involvement documented in Access to Care: Appointments (less than 0.5% of PC contacts completed by supervisory staff). Supervisors who are stretched across too large a span of control cannot provide the direct observation, mentoring, and feedback that clinical quality requires.

Primary Clinician positions have a 25% vacancy rate: Compounding the 25% vacancy rate, Medical Assistants supporting telehealth providers reported being frequently redirected from the ML CCCMS program to assist with medical lines, reducing the effective contribution of telehealth to the clinical mission. The PC vacancy rate also impacts KVSP's ability to offer more clinically oriented groups in their ML EOP and RHU CCCMS program as the provision of these services require the presence of onsite providers.

Telemental health providers reported being excluded from institutional communication channels: Telehealth clinicians reported exclusion from all-staff meetings despite repeated requests for inclusion and noted that new patient care directives were frequently communicated through office technicians rather than through leadership. Onsite leadership was reported to respond to emails with significant delay or not at all. These communication gaps affect the ability of telehealth providers to operate at full productivity and to maintain alignment with institutional clinical standards.

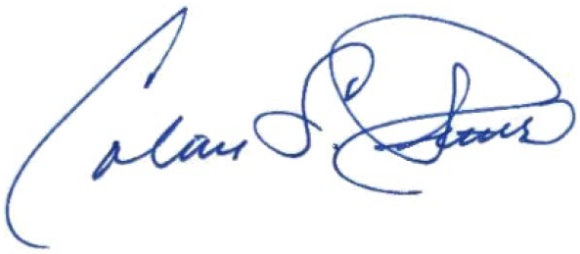
Staff interviews revealed concerns about working conditions and institutional culture: Staff across all levels of care identified insufficient treatment space, a large overflow population, and widespread substance use among patients as persistent barriers to effective care delivery. Some staff expressed concerns about being retaliated against for raising issues, while others praised leadership and reported feeling supported through flexible scheduling and innovative programming. Staff identified misconceptions among clinicians about Milestone Completion Credits and the role of IDTT in level-of-care decisions, suggesting a training need. Concerns about the continuation of retention bonuses were also raised and staff expressed frustration with not being paid a differential for having to report onsite to work.

Recreation Therapist positions were filled at 76%: Given that recreational therapy groups are a component of the ML EOP and RHU CCCMS treatment hour calculations, this vacancy rate contributes to the treatment hours deficit documented in Access to Care: Treatment Offered.

Recommendations

1. Integrate Telemental Health Providers into Institutional Communication Channels: Include telemental health providers in all-staff meeting invitations and ensure they have the technical infrastructure (video conferencing) to participate. Establish a direct communication protocol between telehealth leadership and institutional mental health leadership for dissemination of patient care directives, clinical policy updates, and operational announcements. Discontinue the practice of clinical directives being communicated through office technicians.
2. Protect Medical Assistant Availability for Telehealth Support: Establish a scheduling protocol that ensures medical assistants assigned to support telemental health providers are not redirected to cover medical lines. Identify an alternative staffing source for medical line coverage that does not draw from telehealth support. Track the number of redirections monthly and report to institutional leadership.
3. Increase Staff Awareness of the Mental Health Performance Report: Incorporate key Performance Report metrics into supervisory communications (weekly meetings, huddles) and monthly MHPSC reporting. Conduct a brief training for all clinical staff on how to access and interpret the Performance Report, emphasizing the metrics most relevant to their program area. Encourage the use of weekly supervisory area reports based on performance report metrics used to inform line staff of how their program areas are performing and so that the same information can be utilized for ongoing local quality management and reporting through the local governing body and larger statewide quality management program.
4. Address Clinical Staff Training Gaps on IDTT Level-of-Care Decision-Making: Develop and deliver targeted training on these topics for all clinical staff, integrated with the IDTT quality improvement initiative described in Quality of Care: Care Access.

Receiver's Signature Page



Appendix A: Acronyms and Initialisms

Acronym List	
ASP	Avenal State Prison
APP	Acute Psychiatric Program
ASH	Atascadero State Hospital
BPT	Board of Prison Terms
C&PR	Classification and Parole Representative
CAL	Calipatria State Prison
CC I	Correctional Counselor I
CC II	Correctional Counselor II
CCAT	Correctional Clinical Assessment Team
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEN	Centinela State Prison
CEO	Chief Executive Officer
CHCF	California Health Care Facility
CHSA	Correctional Health Services Administrator
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
CMH	Chief of Mental Health
CNE	Chief Nurse Executive
COR	California State Prison, Corcoran
CPR	Cardiopulmonary Resuscitation
CQIT	Continuous Quality Improvement Tool
CQI	Continuous Quality Improvement
CRC	California Rehabilitation Center
CTC	Correctional Treatment Center
CTF	California Training Facility
D/C	Discharge
DAI	Division of Adult Institutions
DCHCS	Division of Correctional Health Care Services
DOT	Direct Observed Therapy
DSH	Department of State Hospitals
EHRS	Electronic Health Records System
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prisons
HPS I	Health Program Specialist I
HQ	Headquarters

ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
ISP	Ironwood State Prison
ISUDT	Integrated Substance Use Disorder Treatment
KOP	Keep On Person
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
LOC	Level of Care
LOP	Local Operating Procedure
MA	Medical Assistant
MAPIP	Medication Administration Process Improvement Plan
MCSP	Mule Creek State Prison
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
MHPS	Mental Health Program Subcommittee
MHSDS	Mental Health Services Delivery System
ML	Mainline
ML CCCMS	Mainline Correctional Clinical Case Management System
ML EOP	Mainline Enhanced Outpatient Program
MSF	Minimum Support Facility
NA	Nurse Administered
NDRH	Non-Disciplinary Restricted Housing
NDPF	Non-Designated Programming Facility
NKSP	North Kern State Prison
OA	Office Assistant
OT	Office Technician
PBSP	Pelican Bay State Prison
PBST	Positive Behavior Support Team
PC	Primary Clinician
PIP	Psychiatric Inpatient Program
PT	Psychiatric Technician
PVSP	Pleasant Valley State Prison
QIP	Quality Improvement Plan
QIT	Quality Improvement Team
QMSU	Quality Management Support Unit
R&R	Receiving and Release
RC	Reception Center
RHU	Restricted Housing Unit
RHU CCCMS	Restricted Housing Unit Correctional Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment
SAC	California State Prison, Sacramento

SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Camp
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focus Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers
TCMP	Transitional Case Management Program
TTA	Treatment and Triage Area
UM	Utilization Management
UOF	Use of Force
VPP	Vacaville Psychiatric Program
VSP	Valley State Prison
WSP	Wasco State Prison

Appendix B: Suicide Prevention Report

MEMORANDUM

Date:	3/24/2026
To:	Statewide Suicide Prevention and Response – Focused Improvement Team Committee
From:	Leah LeDuc, PhD Sr. Psychologist Specialist Suicide Prevention Unit, Region 3
Subject:	KERN VALLEY STATE PRISON (KVSP) SUICIDE PREVENTION TOUR- QUARTER 1, MARCH 2026

On March 16 through 20, 2026, I conducted an on-site review of KVSP's compliance with statewide suicide prevention and response policies in conjunction with the Receiver's Compliance Team. This report summarizes all findings and concludes with corrective action plans and recommendations. Unless otherwise noted, this audit covered the period August 2025 through January 2026. Mental Health Compliance Team (MHCT) Lieutenant Greg Boyer, Nurse Consultant Mae DeLara Dobles, and Receiver's Compliance Auditor Lindsay Hayes were in attendance during this review and completed Continuous Quality Improvement Tool audits as noted throughout this report.

Restricted Housing

KVSP has two restricted housing units (RHUs). RHU-1 typically houses CCCMS patients, and RHU-2 typically houses GP individuals, however at the time of this visit there were CCCMS and GP patients residing in both units due to the high volume and turnover of individuals housed in RHU at KVSP. Unit B-1 was utilized for RHU Overflow.

RHU Pre-Screening (Pre-Placement)

Review of the OnDemand Performance report indicated compliance for RHU pre-placement screens completed within required timeframes during the audit period was 85% (N=960). This was consistent with KVSP's last review (85%) and is slightly below the statewide average of 87%. RHU pre-placement screenings were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU GP Screenings (Post Placement)

During the audit period, overall compliance with RHU GP screenings was 91%, with generally good compliance throughout the review period (N= 137), consistent with the last review period (92%) but slightly below the statewide average of 95%. RHU GP screenings were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU-1 (CCCMS) and RHU-2 (EOP)

Intake cells

RHU-1 has eight intake cells (101-108). RHU-2 has five intake cells (101-105). MHCT completed a review of RHU cells in conjunction with Mr. Hayes. It was discovered all cells in B-1 RHU Overflow were suicide resistant except for 113 and 122, both of which are wheelchair accessible but have not been retrofitted with suicide-resistant grab bars.

Inspection of RHU 1, RHU 2, and B-1 found that, with one exception, all new intake incarcerated persons were in new intake cells. Three IPs in RHU 1 were in new intake cells beyond the required 72 hours and should have been moved. The exception was an IP housed in a DPW cell, a non-new intake cell. KVSP should retrofit an appropriate number of DPW cells to be suicide resistant.

Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of findings.

Second Watch Morning Meeting

Second watch huddle was observed during this visit with a mental health program supervisor, nursing, psychiatry, and custody sergeant in attendance. RHU-2 huddle was combined with RHU-1 during this visit. All required elements were discussed, including new arrivals, patients on 5-day follow-ups, patients enrolled in Suicide Risk Management Program (SRMP), and patients presenting with recent concerns that contribute to high risk of suicide.

Psychiatric Technician (PT) Rounds

Morning PT rounding was observed by nursing during this review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Access to Entertainment Appliances

MHCT lieutenants reviewed access to entertainment appliances during this review. Patients in the RHU CCCMS and RHU GP & B-1 overflow were in possession of entertainment appliances, and the Automated Restricted Housing Record (ARHR) data demonstrated requirements were met for out-of-cell time, showers, and phone access. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Welfare Check Completion (Guard One)

Guard 1 checks for RHU-1 in February 2026 were within compliance at 91.07%. Guard 1 checks for RHU-2 in February 2026 were slightly below expected compliance at 87.76%. A portion of RHU Guard 1 checks was observed by MHCT during this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of findings.

The B1 RHU overflow does not have Guard 1 capability. The "Security/Welfare Check Manual Tracking Sheets" were reviewed by Mr. Hayes and found up to date, but observation intervals were not staggered as required.

Inpatient Units

Suicide-Resistant Cells

KVSP has one licensed Mental Health Crisis Bed (MHCB) consisting of 12 beds (101-108 and 111-114), all of which have been previously deemed retrofitted in compliance with statewide policy. Three of the 12 beds were "redlined" at the time of this visit (102, due to a broken sink, 104 due to broken window glass, and 111 for clogged toilet and cracked floor tile). On day one of this review, the MHCB census was nine.

Interdisciplinary Treatment Team (IDTT)

Five full IDTTs were observed by mental health reviewers on March 16th, including three initial IDTTs, all for patients admitted for danger to self, one follow-up IDTT with referral to higher level of care for a patient admitted for Serious Impairment Due to Mental Illness (SIDMI), and one discharge IDTT for a patient admitted for

SIDMI. All required team members were present and had access to patient documentation. Appropriately, clinical summaries and treatment goals were presented, and the team reviewed aspects of the safety plan for IPs presenting with suicidal ideation (SI) as well as the level of observation and issue. All team members participated meaningfully in the treatment discussion, however the quality of treatment planning appeared scripted and minimally individualized in three of the five cases, and it was not clear that these patients had a clear understanding of their treatment goals. Of note, one clinician struggled to provide comprehensive case presentations and supplemental interventions were provided by the MHCB supervisor to complete the IDTT process.

Quality of Safety Planning

Safety plans were reviewed for five discharged MHCB patients admitted for suicidality and not referred to a higher level of care. Two of the five plans reviewed were deemed clinically insufficient, relied on overly general interventions, and listed program guide requirements rather than addressing patient-specific triggers for suicidality.

Fifteen safety plans for rescinded MHCB referrals were also audited as part of this review. The quality of evaluations for rescinded MHCB referrals ranged between poor to adequate, with only nine of the fifteen containing adequate justification for rescission. Fourteen of 15 safety plans were not individualized, relied heavily on stock phrasing, and contained nearly identical interventions for each patient. Furthermore, 14 patients had refused a confidential setting for evaluation, and none of the 15 contained patient responses. As this was an issue identified during the previous site review, the corrective action plan (CAP) regarding this concern shall remain open at this time.

In another review of 10 rescinded cases by Lindsay Hayes, all (10 of 10) had the required SREs, and 57 percent (4 of 7) of the applicable daily clinical follow-ups for each of the five required days were completed. Of note, clinicians in three (3) cases incorrectly counted the date and time of the completed SRE as the first day of the follow-up. According to the CMH, that problem was corrected in January 2026. Safety plans were completed in 90 percent (9 of 10) of cases, but most were inadequate and contained cut/paste narrative that was either not individualized or not pertinent to the section of the plan.

MHCB Supervisor Review of Discharge Safety Plans

Review of the On Demand MHCB/PIP Supervisory Reviews of Discharge Safety Plan report indicated that 105 patients referred to KVSP MHCB for danger to self were discharged to lower level of care between August 1, 2025, and January 31, 2026. A supervisory review of the discharge safety plan was completed timely for 42% (N=44) of these discharges, with most missed supervisory reviews occurring in August through October. Several other reviews were either not completed or were completed untimely. As KVSP discharged an average of less than ten patients per week during the audit period, all discharge safety plans should have been reviewed in accordance with the statewide policy. Concerns regarding this process were identified during the last site review, and review of data reflects improved performance since that time, with 100% compliance for January, continued monitoring of this process is recommended to ensure compliance is maintained going forward.

Suicide Watch and Suicide Precaution

During day one of this review, the MHCB census was nine. One patient was on 1:1 suicide watch, three were on suicide precautions, and the remaining five patients in the unit were on Q30 minute checks with full issue. Suicide Watch and Precaution rounding was observed by nursing as part of this onsite review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

The timeliness of suicide precaution rounds during this audit period was good: 97% over the past 6 months, which is in line with the current statewide average of 96%. Compliance with staggering was excellent at 100%.

Timely completion of documentation during suicide watch was 89%, which is below the statewide average of 95%.

Observation and Issue Orders

MHCB staff posted printed issue orders on each patient's door. Observation and issue were reordered daily as required by the memorandum on state-issued clothing and bedding in the MHCB (10-29-2013 and 3-15-2016). Each patient had up-to-date issue and observation orders posted on their door. One patient was observed to be wearing a smock though he had been cleared for partial clothing the previous day. Following intervention by the auditing team, the patient was subsequently issued partial clothing prior to his IDTT meeting. Otherwise, patients generally possessed all ordered items and only those items and no patients had unusual combinations of orders.

To verify whether progress notes contained justifications for orders, I reviewed daily provider contact documentation of all current patients who had been on suicide precaution status since their arrival at MHCB (N=8), and only one patient had adequate justification of issue and observation orders noted for all days on suicide precaution status. Clinically insufficient documents either failed to address issue and observation orders altogether or noted issue and observation status but failed to provide any justification. As this was a concern noted during the previous site review, it is recommended that the MHCB program supervisor review daily justifications for all patients prior to discharge and provide training to staff in real time as needed to ensure consistent compliance.

The one patient in MHCB during this site review that had not been on suicide precaution status was excluded from the CQIT review for that reason. Of note, this patient was initially referred for Danger to Self (DTS), was transitioned from safety issue to full issue and Q30 status after two days and had remained in MHCB for nearly two weeks thereafter.

Privileges

Seven patients who were in the MHCB during this review were there for at least 72 hours. Privileges were audited by MHCT as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

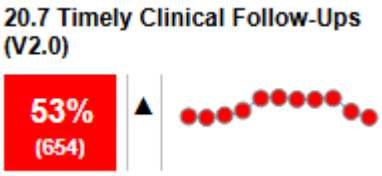
In addition, Mr. Hayes examined the Automated Restricted Housing Record (ARHR) system for documentation of out-of-cell activity for five (5) MHCB patients during seven days of the review period. All had been cleared for out-of-cell activities by providers. The review found that all five patients were offered out-of-cell activity (yard/dayroom) ranging from 6 to 10 hours per week. The average time of out-of-cell activity offered was 7 hours per week. Only one (1) of the five (5) patients was offered a minimum of 10 hours out-of-cell activity during the seven-day periods. All patients were offered between 3 to 5 showers per week, as well as 2 to 7 telephone calls (with an average of 4 calls per week).

Please note that for the MHCB Out-of-Cell Activities Indicator, two scores were calculated onsite. One calculation of out of cell time will exclude any clinical appointments with a Mental Health Clinician, whereas the other calculation will include such appointments. The final methodology of this item will be determined after additional data is gathered and recommendations presented to the Receiver.

Clinical Discharge Follow-ups

Compliance for clinical follow-ups, which has historically been excellent for KVSP, declined significantly after the business rules changed for this indicator in March 2025. While compliance for this indicator is higher than the statewide average of 50 percent, compliance was 53 percent (N= 654) overall for August – January. As of March 2025, the business rule indicates that day 1 of the clinical follow up must occur within 24 hours of discharge from the MHCB. Additionally, follow up compliance is now calculated as compliant or not compliant the entire follow up series, whereas it was previously calculated daily. Currently if one day of the

follow up is out of compliance, the entire follow up is now deemed out of compliance. Changes to these business rules have significantly impacted compliance for this indicator statewide and are currently in the process of being updated to reflect the purpose of the statewide policy, which mandates daily follow-ups beginning the day following physical discharge, rather than within 24 hours.



A random selection of fifteen series of five-day follow-up documentation was audited, and 62/74 (83.78%) of the individual follow-ups reviewed were completed within compliance timeframes. None of the remaining twelve contacts were missed due to the 24- hour rule. In all but one of the series reviewed, the last day was completed by a mental health clinician. Of 74 contacts reviewed, 55 were completed by a clinician and 19 were completed by PTs (KVSP utilizes PTs to complete contacts as needed on weekends and holidays). Safety plans were reviewed for all follow-ups completed by a clinician. As PTs are not required to review safety plans with patients, these individual contacts were excluded from CQIT to avoid falsely deflating compliance for that indicator.

MHCB Rescissions

During the audit period, staff rescinded 608/747 MHCB referrals.

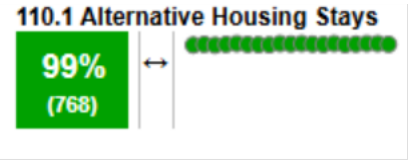
A sample of 15 patients rescinded from alternative housing between August 2025 and January 2026 was selected for review and a safety plan was completed in accordance with policy for all fifteen rescissions. See *Quality of Safety Planning* for a discussion of safety plan quality.

Alternative Housing

KVSP's LOP 1056, *Mental Health Crisis Bed (MHCB) Referral and Referral Rescission Process,* which was last updated in November 2025 and specifies a prioritized alternative housing location list. Primary alternative housing cells are located in the GP Restricted Housing Unit (GP RHU), H Section, cells 196-198. When there is no alternative housing available in GP RHU, IPs are directed to the CCCMS Restricted Housing Unit (CCCMS RHU), H Section, Cells 196-198. Pursuant to the LOP, when there is no alternative housing available in either location, IPs requiring alternative housing will remain in their own facility and be directed to designated alternative housing cells within that facility.

During the site review, there were three patients in alternative housing, all located in C-4 Unit. All designated AHU cells were utilized and the three patients observed in AHU were housed on lower tier, consistent with KVSP's LOP. All three patients were observed on suicide watch status, and nursing staff maintained a clear visual of each patient and were entering observations in EHRS in real time. One patient had been evaluated the night before and was awaiting MHCB placement. Assessments for the remaining two patients were observed, and both were offered confidential assessments. Suicide risk inquiry was inadequate for both cases, as the clinician omitted inquiry of current suicidal ideation and intent, which is intrinsic to assessment of suicide risk and justification of rescission. Of further concern, documentation reviewed from the subsequently completed Suicide Risk Evaluations (SREs) was inconsistent with the auditors' observation of the clinician's interaction with both patients, in that denial of current suicidal ideation and intent was noted in both cases. These concerns were addressed with the Chief of Mental Health immediately thereafter, and the patients were re-evaluated. Given these findings, it is recommended that refresher SRE mentoring be provided to staff as needed, and that all clinicians be reminded to complete the evaluations as written, and to document only what is observed.

On Demand reflects staff admitted 195 patients to the MHCB during the audit period. Patients were admitted within 24 hours, 99% of the time.



Suicide Risk Management Program (SRMP)

On Demand indicated 107 individuals were enrolled in SRMP at the time of this site review, consistent with 112 during the last site visit (December 2025). Per On Demand, no patients met the criteria for SRMP but were not yet enrolled during the time of this audit.

I reviewed the SRMP section of the Master Treatment Plan for five patients currently enrolled in SRMP per the OnDemand indicator. One patient was noted as currently included in SRMP with appropriate treatment plan updates. Treatment plans for the remaining four patients reviewed indicated they do not currently meet criteria for inclusion in SRMP and have not met criteria for the past year. All four patients deemed inapplicable had formally been included with goals and interventions noted for management of suicidality, however none of the four had ever been formally removed from the program. While completing this audit, there were some inconsistencies found between information in the On Demand reports and information in EHRS. This inconsistency has been found at other institutions, and as a result the HQ SPRFIT team has elevated this concern to the quality management programs to further evaluate.

KVSP's MH OP 1031 *Suicide Prevention and Response* was last updated in January 2026 and outlines the most recent SRMP policy and procedures.

Custody Inpatient Discharge Follow-ups

KVSP has a widely varied monthly volume of 7497s: 2-20 per month during the audit period. Review of the Custody Inpatient Discharge Checks Audits indicates overall compliance was 100% in August, 96.2% in September, 96.9% in October, 92.3 % in November, 99% in December, and 91.8 in January. Though these audits reflected overall compliance for the audit period was generally good, areas of concern included missed 30-minute checks and missed supervisor review entries, both of which impacted overall compliance for two months, and checks discontinued after 72 hours, which impacted compliance for November.

These concerns and others were identified during the CQIT review, however overall compliance was notably more problematic. Of 58 7497s reviewed for this audit period, 30 contained no errors, 19 contained missed supervisory reviews, 13 contained missed custody checks, nine were missing the arrival code or the documented time of arrival, two contained missing clinical checks, and anomalies, including missing information on page one of three reviewed, and pre-filled information was noted on the custody checks portions of four 7497s reviewed.

In review of an additional thirty-five 7497s reviewed by Mr. Hayes, 83 percent (29 of 35) had Page 1 of the "Discharge Custody Check Sheet" (CDCR MH-7497) forms completed correctly by mental health clinicians, with most errors attributable to incomplete forms. In addition, 66 percent (23 of 35) of the "custody check" forms (Page 2) were completed correctly by correctional staff at 30-minute intervals, with most errors attributable to gaps in observation and/or use of pre-printed time intervals.

Given these findings, it is recommended KVSP develop a plan to ensure 7497s are reviewed with increased frequency, and errors should be remediated in real time.

Institutional SPRFIT Committee

I was unable to observe a meeting for this audit period, however SPRFIT minutes for August 2025 through January of 2026 were uploaded to the SharePoint site and were reviewed by Mr. Hayes. Quorums were met for all meetings during the audit period, however the SPRFIT meeting template at KVSP incorrectly lists the senior psychologist supervisor as an authorized designee for the chief psychiatrist. Going forward, it is recommended the template be corrected to reflect that the chief psychiatry designee can only be a psychiatrist, in accordance with statewide policy. The September 2025 and January 2026 minutes suggested that clinical summaries of serious suicide attempts were discussed, but there was no proof of practice that they were conducted as stated. It is recommended that clinical summaries be attached to monthly minutes. Meeting minutes included discussion on compliance data, improvement projects, as well as the status of corrective actions based upon regional SPRFIT audits and/or previous Hayes recommendations. In addition, SPRFIT meeting minutes for August, September, and October 2025 simply listed the total number of SRMP patients each month but did not present any tracking/review data.

Table 1. Alignment of Local Policies with Recent Statewide Policies Pertaining to Suicide Prevention

Statewide Memorandum (Date)	In Local Policy?
Alternative Housing (12-12-2012, 5-16-2012)	Yes (OP 1056)
Bad News (4-28-2021)	Yes (OP 1075)
Discharge custody checks (revised 10-10-2021)	Yes (OP 1056)
MHCB Patient Identifier (12-03-2021)	No
SRMP (7-12-2021)	Yes (OP 1031)
SRE Mentoring (revised 7-12-2022)	Yes (OP 1017)
Cut-Down Kit (revised (8-10-2022)	Yes (OP 1051)
Safety Concerns (revised 9-21-2022)	Yes (OP 1058)
Security Welfare Checks (revised 10-7-2022)	Yes (OP 200 and OP 210)
Safety Planning (2-13-2023)	Yes (OP 1032)
Discontinue Safety Contracts (1-23-2023, 2-17-2023)	No
Update to SRE Mentoring Program (6-7-2023)	Yes (OP 1017)
Clinical reviews for serious suicide attempts (6-14-2023)	Yes (OP 1058 and OP 1051)

Policies

KVSP has local suicide prevention policies that address required suicide prevention trainings, Discharge Custody Check requirements, SRMP, documentation of self-harm events, receipt of bad news, Crisis Intervention Team procedures and provision of postvention care following deaths by suicide. Mr. Hayes reviewed the policies to verify that recent statewide memoranda related to suicide prevention has been incorporated into local policy and discovered that none of their local policies address discontinuing the use of safety contracts or posting issue and observation orders and updating them daily in MHCB. As KVSP is aware of these expectations and has been adhering to the policies prescribed in each of these memoranda, this concern does not rise to the level of a Corrective Action Plan (CAP) at this time, however it is recommended that local policies be updated to reflect these statewide expectations. The results of the policy audit are presented in Table 1.

Severe Self-Harm

Per the SPRFIT report, the 6-month rate for self-harm incidents at KVSP was 6.3 per 1,000, higher than the statewide average of 5.3, between September 2025 and February 2026. There was one death by suicide in October, by hanging, and no self-harm events requiring significant medical intervention.

Inmate Family Council

During this audit period, the local SPRFIT coordinator or MH designee attended Inmate Family Council (IFC) October 17. Date of attendance was noted in SPRFIT Subcommittee minutes; however, the meeting agenda was not discussed for this date.

Inmate Advisory Council/Patient Advisory Council

During this audit period, the local SPRFIT Coordinator or MH designee attended Inmate Advisory Council (IAC) on September 8th, and October 23rd. Dates of attendance and council agendas were included in SPRFIT Subcommittee meeting minutes.

Suicide Risk Evaluations

Timelines for Suicide Risk Assessment

A total of 1,539 SREs were completed at KVSP during the audit period (August 1, 2025- January 31, 2026) with 73% overall compliance per On Demand. For this audit period, compliance of SRE sub-indicators is as follows:

- Emergent consults for DTS: 98% (N=857)
- Urgent consults for DTS: 100% (N=1)
- Routine consults for DTS: n/a
- At MHCB clinical discharge: 97% (N=137)
- Upon MHCB referral for DTS: 53% (N=729) *down from 99% (N=539)*
- Upon rescission of MHCB referral for DTS: 98% (N=599)
- Upon arrival from PIP: 100% (N=1)
- Upon arrival from DSH: 67% (N=3)
- 30-day assessments following MHCB discharge: 8% (N=36)
- 90-day assessments post-MHCB discharge: 29% (N=28)

Overall compliance for this indicator decreased from 95% during the last site review, to 73%, with SREs completed upon referral to MHCB as one the primary areas of decreased compliance (53% down from 99% during the last site review). Though the changes to the business rules for the MHCB referral indicator have changed in recent months to accurately reflect current statewide policy, concerns regarding meeting timelines for after-hours referrals have been identified, which are negatively impacting compliance. Headquarters staff have proposed policy language changes to better align with the intent of the indicator. Because of these changes, there has been a significant decrease in compliance for SREs following MHCB discharges, even though the number of required assessments decreased significantly. The Current Due Dates report is being modified to address concerns from the field that these assessments are not populating correctly, which has impacted timely scheduling.

Urgent and Emergent Consults for Danger to Self (DTS).

KVSP classified all DTS consults as emergent (857/858) during this audit period (August 2025-January 2026).

A review of the performance report indicated an overall compliance rate of 97% for Emergent and Urgent mental health referrals that result in an SRE. This was consistent with their Quarter 4, 2025 compliance rate of 97%.

	Measurements	Hour Overdue	Compliance
Emergent and Urgent MH Referrals That Result in SREs	876	7.6	97%
SRE after Emergent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	857	5.3	98%
SRE after Emergent MH Consult for suspected intentional drug overdose	3	0.0	100%
SRE after Urgent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	1	0.0	100%
SRE after Urgent MH Consult for suspected intentional drug overdose	15	145.0	53%

Lindsay Hayes reviewed a sample of 15 urgent and emergent referrals that were not placed for DTS but required full SREs. Of the fifteen cases reviewed, twelve (80%) had the required full SRE completed. In several cases reviewed, the abbreviated SRE reassessment form was incorrectly utilized in lieu of the full form.

Emergency Response

Cut-Down Kits

The Mental Health Compliance Team reviewed cut down kits as part of this review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

One QIP remained open from suicides which occurred prior to KVSP's last site visit. Three suicides occurred at KVSP in 2025: on May 6, May 21, and October 20. There were no QIPs generated from the suicide occurring on May 21.

The following mental health QIPs were generated from the suicide occurring on May 6, 2025:

Problem	Quality Improvement Plan	Current Status
On May 6, 2025, the MHPC Assessment Note provided a Subjective/History of Present Illness nearly identical in content to the Clinical Summary and Case Formulation section, both of which were extracted directly from April 9, 2024 MH Master Treatment Plan Case Formulation. The reference for these portions of the note, which had been copied and pasted, unedited, did not include a citation. This rendered documentation confusing, with the potential to perpetuate outdated or potentially inaccurate data and obscure clinical decision-making. Clinical documentation must be unique for each patient's contact and in the case of citations, accurately include the origin.	**The CMH and/or designee at KVSP** shall review the identified concern and determine the best course of action.	The CCCMS/EOP Supervisor met with the identified clinician and training on documentation was provided. Supervisors will continue to monitor and provide direction and training pertaining to documentation. **Update:** While treatment plan case formulations were not specifically audited as part of this review, cutting and pasting was evident in review of safety plans. Continued monitoring is recommended

Over the past year in CCCMS, the incarcerated individual was seen late for the two consecutive MHPC contacts prior to his death. He was seen for an MHPC contact on July 29, 2024, and then seen beyond 90 days for his next MHPC contact on November 26, 2024. His final MHPC contact occurred on May 6, 2025, which was also beyond 90 days from his previous contact in November 2024. While adherent to the KVSP Triage Plan, the CCCMS MHPC contacts at KVSP failed to meet the 2021 Revision MHSDS Program Guide 2.1.22 requirements. The critical staffing shortage at KVSP resulted in an inability to provide timely MHPC contacts.	**The Chief of Mental Health (CMH) and/or designee at Kern Valley State Prison (KVSP)** shall review the local triage plan considering the identified problem to determine if any changes are indicated.	KVSP submitted the most recent triage plan for Mental Health. **Closed.**
On May 4, 2025, the SRE was administered to the incarcerated individual in the short, rather than long form. Per documentation, he had subjective reports of suicidality with suicidal ideation, as well as least two of the five correctional environmental dynamic factors present (i.e., new safety concern, new single cell placement in RHU). This failed to meet expectations of the Memorandum: New Suicide Risk Evaluation Form and Expectations dated: 08/19/2024.	**The CMH and/or designee at KVSP** shall review the identified concern and determine the best course of action. At minimum, clinical staff at KVSP should be re-trained on the *New Suicide Risk Evaluation Form and Expectations* memorandum .	In response to the QIP, all mental health clinical staff attended training in June and July of 2025 related to the new expectations outlined in the Memorandum: New Suicide Risk Evaluation Form and Expectations (dated: 08/19/2024. Staff were provided with handouts and examples as well as given the opportunity to ask questions. Supervisors will continue to monitor this issue and new staff will be trained in these issues. **Update:** 20/20 SREs audited as part of this review utilized the correct version of the form. This QIP can be closed.
On May 6, 2025, MHPC documentation was unclear as to why the incarcerated individual had been seen non-confidentially. According to available documentation, the incarcerated individual was not provided with confidential contact. Clinical documentation must accurately reflect the circumstances associated with why non-confidential, cell front contacts occurred.	**The CMH and/or designee at KVSP** shall review the identified concern and determine the best course of action.	In response to the QIP, all mental health clinical staff attended training in June and July of 2025 related to confidentiality and documenting the reason for referral. The Evaluations in Private and Confidential Settings Memorandum dated 10/7/2015 was reviewed with staff. Staff were provided handouts and examples as well as given the opportunity to ask questions. Supervisors will continue to monitor this issue and new staff will be trained in these issues. **Update:** documentation of confidentiality appears to have improved. This QIP can be closed

A psychiatry contact that was accomplished on October 3, 2024 would have required that the incarcerated individual (a CCCMS patient) be seen on or before January 1, 2025 (but the next psychiatry appointment appears to have been scheduled for January 17, 2025). A psychiatry contact that was accomplished on January 30, 2025 would have required that the patient be seen on or before April 30, 2025 (but the next psychiatry appointment appears to have been scheduled for May 6, 2025). Scheduling of psychiatry appointments was untimely.	**The Chief Psychiatrist or designee at Kern Valley State Prison** will research the reason for untimeliness of psychiatry appointments, discuss details with relevant staff (which may include schedulers) and implement a strategy to prevent future occurrences.	The Chief Psychiatrist provided training to the KVSP psychiatry team regarding psychiatry treatment timelines. The psychiatry team was given the opportunity to ask questions and discuss the process. **Closed.**

The following mental health QIPs were generated from the suicide occurring on October 20, 2025:

Problem	Quality Improvement Plan	Current Status
The Mental Health Master Treatment Plan dated October 15, 2025, was missing information in the clinical summary and case formulation, important for treatment planning at the EOP LOC.	**The CMH and/or designee at KVSP** shall review the circumstances involving this concern and identify a plan to ensure documentation is in accordance with the Program Guide requirements.	In response to the QIP, the tele-mental health supervisor provided training to the clinician. Specifically, training was provided on documenting case formulations related to *Performing Clinical Case Formulations in CDCR* (BET I 1063884). The clinician was also instructed to attend *IDTT: An Overview of the Clinical Thinking and Process*. Supervisors will continue to monitor documentation related to IDTT and provide ongoing education as needed. Further, newly hired staff will also be trained on the policies regarding appropriate case formulation, IDTT documentation, and treatment planning.
Psychiatry: Treatment team meeting was held on October 15, 2025. "Master TxP Psychiatry Review" PowerForm was not completed.	**Chief Psychiatrist or designee** will instruct psychiatry staff to complete the Master TxP Psychiatry Review PowerForm in all instances. Attendance at instructional meeting or acknowledgement of receipt of email instructions will be reflected on 844 attendance sheet or similar.	In response to the QIP, the Chief Psychiatrist provided training to the identified psychiatrist. Specifically, identified psychiatry staff was instructed to complete the Master Treatment Plan Psychiatry Review PowerForm in all instances. Ongoing auditing was conducted, and further feedback was provided. Supervisors will continue to monitor this issue moving forward.

Mental Health and Custody: It was discovered during the review process that the incarcerated individual was unable to attend at least two (2) MHPC appointments in the month of October, just two weeks prior to his death. These two contacts were recorded as refusals. Upon further review, the incarcerated individual did not refuse the contacts, but custody was unable to facilitate the appointment based on the lack of available out-of-cell clothing (jumpsuits). The lack of available appropriate out-of-cell clothing has been identified in the past and continues to be an ongoing urgent concern in the KVSP RHU.	**Warden and Chief of Mental Health or designees at KVSP** shall review the circumstances involving this concern and identify a plan to ensure appointments, in accordance with the Program Guide requirements, are able to be attended.	In response to the QIP, the RHU supervisor provided training to the identified staff member. Specifically, policy related barriers to providing telemental health treatment were reviewed. Real time communication related to barriers with both onsite supervisors as well as telemental health supervisors was addressed. Supervisors will continue to monitor this issue moving forward.

Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training for 2025 was excellent. Overall Compliance for custody was 100%, medical was 100%, and mental health staff was 100%.

Compliance with Coleman training requirements is very good, apart from SRE mentoring, which decreased below compliance at the end of 2025 due to staffing changes. Mentoring compliance improved from 76.4% to 83% since their last site visit in December 2025.

Compliance for KVSP as of February 2026 is as follows:

- *Understanding and Assessing the Presence, Severity, and Risk of Suicidality:* 94%
- SRE Mentoring: 83%
- Safety Planning: 90%
- Suicide Risk Management Program (SRMP): 96%
- Complex Cases: 98%
- Prohibition of safety contracts: 98%
- Nursing CPR: 100%
- Custody CPR: 100%

Annual IST Suicide Prevention Training – Observation

Annual IST suicide prevention training was observed as part of this review and was deemed to be satisfactory. The presenter engaged the class and covered all the material as required.

Receiving and Release (R&R) Screening

R&R screening was observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Reception Center Processing

KVSP is not a reception center.

Crisis Intervention Team (CIT)

KVSP's local OP 1055 *Crisis Intervention Team* was last updated in June 2025, and it serves as the institution's CIT policy. This policy specifies that the operating hours for CIT are 0700-1600, Monday through Friday, and KVSP's local OP 1056 *Mental Health Crisis Bed Referral and Referral Rescission Process* speaks to management of emergent referrals during non-business hours. During mental health business hours at KVSP, reports of suicidality are treated as mental health emergent referrals, and CIT is only activated if the clinician determines that a custody or medical issue is present. There were not any CIT calls observed during this review.

According to the CIT report, the correct composition of the team was present in 100% of cases and the IP was referred to MHCB in 18% of all cases seen by CIT. Nursing documentation was completed in 75% of cases.

Active Corrective Action Plans (CAPs)

CAPs are in various stages of completion, as noted in Table 2. Unless otherwise noted in the tables, all CAPs will remain open until the next site visit. CAPs marked as "completed" are considered closed and will not be carried forward into future reports. CAPs marked as "substantial," except for suicide precaution rounds, indicate marked progress or that the CAP has been preliminarily met, with sustainability to be assessed at the next site visit.

Table 2. Status of Open CAPs

Source/Date	*Problem*	*Progress*
Regional Q4 2025	Quality of safety plans was deemed clinically insufficient	14/15 SPs for rescinded MHCB referrals were deemed clinically insufficient and this CAP remains open.

CONCLUSION

A formal exit was held with the Warden, CEO, Chief Psychiatrist, Chief Nursing Executive, SPRFIT coordinator, and other key executives and managers. There were no CAPs closed during this review.

One HQ CAP remains open as of this review:

1. **From Q4 2025**: Quality of safety plans were deemed clinically insufficient. **Update**: fourteen of fifteen safety plans reviewed for rescinded MHCB referrals were not only inadequate, but nearly identical. Given these findings, Safety Plan refresher training is recommended for all staff, but it should be mandatory for staff routinely assigned to see emergent MH referrals. It is also recommended that ten safety plans for rescinded MHCB referrals be reviewed monthly with individual mentoring provided as necessary for inadequate safety plans. This CAP can be closed when refresher training is provided and 90% of safety plans reviewed are deemed clinically sufficient for a period of at least three months.

As a result of this review one new HQ CAPs is assigned:

1. Daily provider contact documentation of all current patients who had been on suicide precaution status since their arrival at MHCB reflected only one patient of eight reviewed had adequate justification of issue and observation orders noted for all days on suicide precaution status. Clinically insufficient

documents either failed to address issue and observation orders altogether or noted issue and observation status but failed to provide any justification. As this was a concern noted during the previous site review, it is recommended that the MHCB program supervisor review daily justifications for all patients prior to discharge and provide training to staff in real time as needed to ensure consistent compliance. This CAP can be closed when 90% of daily provider documentation reflects justification of issue and observation orders for a period of at least three months.

As a result of this review, the following actions are recommended:

1. Supervisory review of the discharge safety plan was completed timely for 42% (N=44) of MHCB discharges, with most missed supervisory reviews occurring in August through October. As KVSP discharged an average of less than ten patients per week during the audit period, all discharge safety plans should have been reviewed in accordance with the statewide policy. As concerns regarding this process were identified during the last site review, and review of data reflects improved performance since that time with 100% compliance for January, continued monitoring of this process is recommended to ensure compliance is maintained going forward.
2. It is recommended that KVSP update local policies to address discontinuing the use of safety contracts as noted in the statewide memorandum *Discontinue the Use of Safety Contracts*, February 27, 2023, well as the daily posting issue and observation orders in MHCB as prescribed in the statewide memorandum *Mental Health Crisis Bed Patient Identifier on Cell Door*, December 3, 2021.
3. Enough ADA new intake cells should be retrofitted within the RHUs to accommodate IPs in need of wheelchair accessibility. To determine this number, the average number of DPW patients could be determined over a six month to one year period who arrive at KVSP who need an intake cell.
4. The Institutional SPRFIT Committee template should be corrected to reflect the chief psychiatry designee can only be a psychiatrist, in accordance with statewide policy.
5. Clinical summaries of serious suicide attempts should be attached to monthly SPRFIT minutes to demonstrate proof of practice.
6. It is recommended that the SPRFIT Coordinator or designee review a sample of 5 urgent or emergent referrals not placed for DTS monthly to ensure the full version of the SRE form is utilized when appropriate. The abbreviate SRE reassessment form is only appropriate to be utilized when a full SRE had been previously completed within the past 30 days.
7. It is recommended KVSP develop a plan to ensure 7497s are reviewed with increased frequency, and errors be remediated in real time to improve compliance with both clinician and custody responsibilities for Custody Inpatient Discharge Follow-up forms.
8. KVSP should develop a plan to increase SRE mentoring compliance to 90%.

KVSP's focus should remain on resolving the above recommendations and newly assigned CAP, and previously assigned HQ CAP, as well as maintaining compliance with the previously closed HQ SPRFIT Coordinator Site Review CAPs.

Please ensure all assigned SPRFIT CAPs are updated on the Improvement Priorities List and Project Pipeline. All SPRFIT CAPs should be listed as an Issue and monthly audit data indicated in the Comment section each month on the Improvement Priorities List and Project Pipeline. The project pipeline is to be uploaded to the SharePoint site monthly.

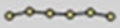
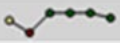
Appendix C: MAPIP

INSTITUTION 6 MONTH TREND

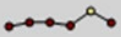
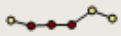
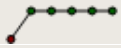
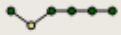
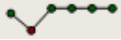
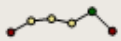
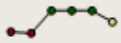
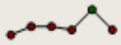
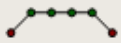
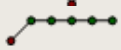
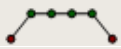
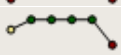
Kern Valley State Prison (KVSP)

January 2026

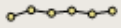
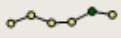
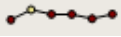
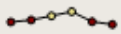
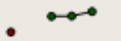
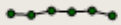
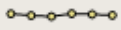
Report Range: *Six Month Average*

Population Health Management	6 Months	Trend	AUG	SEP	OCT	NOV	DEC	JAN
Diagnostic Monitoring (All)	81%		80%	84%	82%	81%	83%	79%
QT Prolongation EKG 12 Months	92%		88%	67%	100%	100%	100%	92%
Antipsychotics (All)	85%		85%	88%	86%	86%	84%	81%
Lipid Monitoring	62%		59%	73%	71%	61%	59%	55%
Blood Sugar	73%		73%	76%	82%	78%	68%	64%
EKG	100%		-	100%	100%	-	100%	-
AIMS	83%		88%	87%	80%	85%	81%	80%
Med Consent	85%		81%	89%	93%	80%	86%	80%
CBC with Platelets	81%		87%	93%	75%	90%	76%	72%
CMP	83%		93%	87%	71%	86%	86%	79%
Thyroid Monitoring	73%		83%	83%	60%	65%	76%	69%
Blood Pressure	99%		98%	99%	98%	100%	100%	99%
Height	95%		96%	97%	91%	97%	95%	96%
Weight	98%		96%	98%	98%	99%	100%	98%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	100%		100%	100%	100%	-	100%	-
Blood Sugar	-		-	-	-	-	-	-
Lipid Monitoring	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
EKG	100%		100%	-	-	-	-	-
AIMS	100%		-	100%	100%	-	-	-
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Blood Pressure	-		-	-	-	-	-	-
Height	100%		-	-	-	-	100%	-
Weight	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-

KVSP CQI Report | 2026

Mood Stabilizers (All)	74%		69%	74%	74%	70%	88%	74%
Carbamazepine (All)	57%		-	-	0%	-	-	100%
Carbamazepine Level	50%		-	-	0%	-	-	100%
CBC	50%		-	-	0%	-	-	100%
CMP	50%		-	-	0%	-	-	100%
Med Consent	100%		-	-	-	-	-	100%
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	74%		75%	68%	70%	69%	87%	77%
Med Consent	83%		33%	100%	100%	100%	100%	100%
Blood Pressure	98%		100%	80%	100%	100%	100%	100%
Height	93%		100%	80%	93%	89%	90%	100%
Valproic Acid Level	46%		50%	75%	25%	33%	50%	55%
CBC with Platelets	53%		63%	55%	42%	17%	86%	55%
CMP	51%		67%	60%	42%	14%	67%	55%
Weight	95%		91%	60%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	79%		65%	84%	88%	80%	100%	67%
Lithium Level	73%		80%	80%	67%	75%	100%	50%
Thyroid Monitoring	77%		63%	60%	100%	100%	100%	80%
CMP	64%		50%	67%	67%	60%	100%	60%
CBC	82%		67%	100%	100%	100%	100%	67%
EKG	78%		-	75%	100%	0%	100%	-
Med Consent	94%		67%	100%	100%	100%	100%	100%
Height	83%		50%	100%	100%	100%	100%	50%
Weight	90%		80%	100%	100%	100%	100%	50%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	72%		64%	72%	83%	66%	81%	67%
CBC	69%		61%	64%	82%	60%	86%	67%
CMP	70%		65%	62%	80%	67%	86%	67%
Med Consent	79%		70%	100%	87%	73%	75%	67%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	78%		-	100%	50%	100%	50%	100%
Antidepressants (All)	77%		77%	79%	80%	73%	74%	76%
EKG (Tricyclics)	100%		-	100%	-	-	-	-
Med Consent	81%		82%	82%	86%	80%	77%	75%
Thyroid Monitoring	53%		49%	62%	49%	39%	51%	68%
Venla Blood Pressure	98%		100%	100%	100%	96%	100%	95%
Pregnancy	-		-	-	-	-	-	-

KVSP CQI Report | 2026

Medication Management	6 Months	Trend	AUG	SEP	OCT	NOV	DEC	JAN
Medications Received Timely (All)	**77%**		**77%**	**76%**	**76%**	**78%**	**77%**	**77%**
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – CTC	-		-	-	-	-	-	-
Intra-System (Within Institutions) – GP	74%		75%	78%	71%	75%	75%	71%
Intra-System (Within Institutions) – RHU	86%		82%	89%	86%	88%	85%	88%
Intra-System (Within Institutions) – MH Inpatient	83%		77%	87%	78%	79%	92%	88%
Intra-System (Within Institutions) – Specialized Medical	95%		99%	96%	88%	93%	97%	95%
Inter-System (Between Institutions) – GP	72%		68%	78%	73%	73%	69%	73%
Inter-System (Between Institutions) – RHU	84%		81%	83%	85%	92%	81%	84%
Inter-System (Between Institutions) – MH Inpatient	88%		90%	89%	77%	90%	88%	89%
Inter-System (Between Institutions) – Specialized Medical	77%		-	-	-	-	-	77%
Return to CDCR – GP	74%		71%	73%	77%	82%	71%	68%
Return to CDCR – RHU	86%		88%	84%	71%	-	97%	96%
Return to CDCR – MH Inpatient	88%		-	88%	-	-	-	-
Return to CDCR – Specialized Medical	87%		66%	-	92%	93%	100%	-
Stable Housing	77%		77%	76%	75%	78%	77%	77%
Leaving CDCR	97%		97%	95%	100%	99%	100%	95%
By Provider Type								
Psychiatry	82%		83%	82%	81%	83%	83%	82%

Appendix D: Sustainable Process Report

Site Visit Report for California Department of Corrections and Rehabilitation
KERN VALLEY STATE PRISON

MAJOR SUSTAINABLE PROCESS REVIEW

Quarter 1 2026
March 16-20, 2026

Sustainable Process Data Review and IPC Interview

Program Area Reviewed: IPC Interview	**Sustainable Process Data Review: 27%**
During the review period of October 1, 2025, through December 31, 2025, HQ resulted in 27% (10/37) compliance for acceptable documentation for non-referral to a higher level of care and the IPC's audit resulted in 70% (26/37) compliance. This shows a decrease from the prior quarter for HQ rating (31% last quarter) and for inter-rater reliability. This quarter the IPC and HQ had a difference of opinion in 43% of the cases reviewed (16/37). Reasons for the unacceptable documentation findings included no clinical opinion regarding treatment refusal, copy-pasted from previous HLOC form, missing or incomplete MSE, wrong HLOC form reviewed, and no input from patient regarding reasons for treatment refusal. In addition to the HQ Sustainable Process Review, the local IPC conducts monthly audits of twenty-five cases (October: 64%, November: 68% and December: 81%). In review with the IPC, he stated, as he had in all previous audits, that there is no interrater reliability in existence to help with discrepancies between HQ's clinical opinion and the IPC's clinical opinion for non-referral to a higher level of care leading to continued clinical differences in opinion.	
Follow-up required: **YES X NO**	**If YES: Follow-Up Date: Midpoint teleconference and** **Routine Review during Q1 2026**
Follow-Up Action Plan: 1. Review and follow CQIT Tool recommendations for HLOC consideration documentation during IDTT's. 2. Program Supervisors will identify PCs whose documentation consistently does not meet audit expectations and should initiate the Progressive Discipline Process.	

Program Area Reviewed:	**Mental Health Subcommittee Minutes/Monthly Audits/Table V**
Monthly Mental Health Program Subcommittee During the review period, monthly subcommittee (MHPS) meetings occurred on 09/23/2025, 10/28/2025, 11/20/2025, 12/18/2025 and 01/28/2026. Based on the meeting minutes, quorum was met with the IPCs or designee present at each meeting. Every month the IPCs or designee shared a high-level of care overview from Table V during the meeting which was captured in the minutes, and Table V was included. All necessary areas related to HLOC referrals were discussed as appropriate within the Mental Health Program Subcommittee.	

Follow-up required: YES:X NO	If YES: Follow-Up Date: Routine Review in Q1 2026

Follow-Up Action Plan:

1. HLOC documentation declined steadily from 31% last quarter to 27% this quarter and continues to be below the threshold of 85% on the HQ audits. As such, it is highly suggested there be an action item created for ongoing review of the MH Subcommittee Meeting related to the HLOC documentation.

Program Area Reviewed:	Acute-ICF Referral and Non-Referral Reports

PIP/DSH Referral Process

During the review period (October 1st through December 31, 2025) there were 8 referrals total: 6 to Acute and 2 to ICF. One of eight referrals was not submitted timely to the MH UM department (88%); no referrals were rescinded. Seven of the eight referrals to MH UM were timely. Five of the eight patients transferred timely to their inpatient unit (63%).

PIP/DSH Returns

During the review period (October 1st through December 31, 2025), there were 23 PIP/DSH returns to KVSP (17 from ICF and 6 from Acute). The required contacts and documentation completion compliance were as follows: Mental Health Evaluations completed within 24 hours were at 61% (14/23); 9 were completed late. The timeliness of the Discharge Summary Review was 83% (19/23); it was reported that one patient returned to a MHCB which was inaccurate information based on the Patient Placement History report in OnDemand. PC-to-PC contacts were at 78% (18/23; with one patient returned to the MHCB). Completion of Five-Day follow-ups was 78% (18/23) with days missed landing on weekends and Friday.

During the IPC interview we discussed the missed SRE's with a recommended solution for the IPC to suggest that SRE's not be postponed until an MHPC can complete them the following work week. The 5 Day Follow-Up's have also been a concern during weekend coverage. The IPC agreed to order the 5-Day Follow-up orders in EHRS on Fridays and include Psychiatric Technicians on the distribution email list sent every Friday to ensure updated information is received regarding incoming new arrivals. Another concern highlighted was the missed PC-to-PC contacts; The IPC agreed to start including the PIP supervisors in the reminder emails sent to the line staff with the understanding that the supervisor can conduct the PC-to-PC contact if the assigned MHPC is unavailable.

Acute- ICF Non-Referrals

The On Demand Acute-ICF Non-Referral reports were reviewed for October, November and December 2025. Across the review period, there were 385 entries for 269 patients in which higher level of care considerations was met during IDTT, but the patient was not referred to a HLOC. Across the review period, several patients had more than one IDTT due to MHCB placements, referrals to Acute and some including their initial IDTTs following discharge from a MHCB to a lower level of care. Several patients also had multiple IDTTs due to transfers between ML and RHU housing and/or LOC changes.

Across the quarter, the most frequently occurring indicator was for Treatment Refusal/Minimal Participation (235/385), MHCB referrals (152/385), MH RVR Assessments (105/385), and MHCB overstays (2/385). Upon a sample review of the reasons for Treatment Refusal/Minimal Participation there was no common theme. Some of the individual reasons included: discomfort in large groups, substance use, poor insight into the need for mental health treatment, new arrival adjusting to environment, not called to group, paranoia and lack of motivation. MHCB referrals most were due to Danger to Self. Multiple patients had more than one positive indicator (107/385).

Follow-up required: YES X NO	If YES: Follow-Up Date: Q4 2025

Follow-Up Action Plan:

1. Referrals to the PIP/DSH decreased from 22 referrals last quarter to 8 referrals this quarter. Upper management is encouraged to discuss possible HLOC referrals with their MHPC's to ensure needed referrals are not missed.
2. It is recommended that the CMH work with the IPC and Program Supervisors, and ensure completion of documentation related to PIP returns is timely and includes a process for follow up of patients transferring to their units.

Program Area Reviewed:	Documentation Review: Higher Level of Care Considerations for Internal Consistency

Review of Clinical Documentation Associated with HLOC Justification/ HLOC Internal Consistency
Of the eight cases reviewed two cases are still pending review. Of the six cases completed, three of the decisions for non-referral to a higher level of care were supported by prior documentation. This is a decrease from the prior quarter in which seven of the eight were found to have supporting documentation for the rationale for non-referral.
In one case in which the narrative lacked justification for non-referral to HLOC was because the provider did not provide rationale for the high treatment refusal/lack of treatment participation and instead explained reasons for the patient's RVR's. Furthermore, because this IDTT was completed in absentia it did not reference recent contact with the patient or overall functioning based on prior PC contacts. In the second case, the MTP did not account for the MHA outcome that opined mental illness did contribute to the behavior that led to the RVR and the HLOC noted the patient had good sleep which was inconsistent with ongoing documentation that the patient struggled with nightmares and poor sleep which contributed to high treatment refusal. The third case that lacked justification for non-referral to a HLOC also did not account for a MHA that was dismissed, but opined mental illness did contribute to the behavior that led to the RVR: RVRs were attributed to impulsivity and substance-related behavioral dysregulation.

Follow-up required: YES X NO	If YES: Follow-Up Date: Routine Q4 2025 review

Follow-Up Action Plan:

1. The random 8's in this quarter resulted in a decline from the previous quarter. Clinical documentation expectations continue to be an area needing improvement.

- **Higher Level of Care Considerations Documentation**

The HQ review for this quarter continued to show documentation falling below the 85% threshold to 27%. (Q4 2025= 31% Q3 2025= 43% Q2 2025= 43%, Q1 2025= 46%, Q4 2024= 46%)
It should be noted that KVSP continues to have significant and consistent declines in this area as they consistently fall below the 85% mark.
Primary Clinicians should continue to incorporate the following recommendations:

- Review the Sustainable Process Report for each patient on the day of IDTT.
- Integrate a discussion of the HLOC Considerations into the IDTT presentation and document the rationale for non-referral (if MH improvements occur explain this in detail).
- Know the expectations for the HLOC documentation and audit criteria.
- Include indicators of current functioning and mental status that support non-referral.
- Review the final HLOC documentation and consult with IPC as needed.

Senior Psychologist Supervisors should continue to:

- Review the Sustainable Process Report from On Demand on the day of the IDTT to ensure that Higher Level of Care Considerations are discussed and documented in EHRS and completed accurately. Monitor and prompt clinicians as needed.
- Review the expectations related to HLOC items #5, 6, 7 and ensure the discussion and documentation meets the expectations.
- Provide training and mentoring to clinicians who continue to fail to meet the expectations for HLOC review and documentation.
- Ensure that clinicians HLOC documentation includes both clinical opinions and the patient's reported reasons for treatment refusal.
- Ensure the documentation for EOP modified treatment plans includes clinical support for the initial and ongoing modified programming.
- Review the final HLOC documentation and request timely adjustments, including a new IDTT when clinically indicated.

The IPC is encouraged to continue the following:

- Consult with the treatment team regarding decision-making and documentation for all positive Higher Level of Care Considerations prior to IDTT.
- Attend as many IDTTs as possible for patients identified for consideration for HLOC.
- Review the final HLOC documentation and request timely adjustments, including a new IDTT when clinically indicated.
- Confirm that the requested corrections have been completed and documented in EHRS.
- Continue to provide training and mentoring to clinicians who continue to fail to meet the expectations for HLOC review and documentation.
- Include the supervisors and CMH in the ongoing process and present the information at the monthly Subcommittee meetings.

SITE VISIT SUMMARY

Review of non-referrals to a HLOC for Q4 2025 and Q1 2026, found acceptable documentation continues to fall below the 85% threshold: Q1 2026 resulted in 27% compliance and Q4 2025 was 31% compliant (Q3 2025= 43% Q2 2025= 43%, Q1 2025= 46%). PIP referrals increased to 22 referrals during Q4 2025 but dropped significantly with a total of eight for Q1 2026. A review of the APP referrals for each quarter found the current process to result in the overall timely submission of all referrals during Q4 2025 and Q1 2026. The expectations for contacts and documentation on patients returning from a PIP have shown a decline in consistency from Q4 2025 to Q1 2026 with decreasing compliance in each of these areas.

While there are areas in need of improvement, KVSP continues to make efforts to provide treatment for their patients and continues to show areas of improvement despite staffing shortages, and modified programming limitations. The Regional mental health team will continue to monitor and support the leadership at KVSP in meeting their goal of a self-sustained quality mental health program.

Appendix E: Excluded Indicators

- Patients Referred to MHCB on Continuous Direct Visual Observation
- Patients in Alternative Housing with a Bed
- Scheduled MH Appointments Completed or Refused
- Mental Health Primary Clinician Continuity of Care
- Mental Health Psychiatrist Continuity of Care
- Healthcare Staff CMHPP Annual Training
- Monthly Review of EOP Modified Treatment
- ICCs with MH Clinicians Present and Relevant Information Provided
- Institution SPRFIT Meetings Observed that Satisfy All Audit Criteria