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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

April 2026

Cycle 7

Medical Inspection Report

California Health Care Facility

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated people[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, including clinical case review and compliance testing. Together, these methods assess the institution's medical care on both individual and system levels by providing an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk, who tend to access services at the highest rate. Through these methods, the OIG evaluates the performance of the institution in providing sustainable, adequate care. We continue to review institutional care using 15 indicators as in prior cycles.[3]

Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the medical inspection tool (MIT). In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff. The OIG determines a total compliance score for each applicable indicator and considers the MIT scores in the overall conclusion of the institution's compliance performance.

In conducting in-depth quality-focused reviews of randomized cases, our case review clinicians examine whether health care staff used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient. At the same time, our clinicians consider whether institutional medical processes led to identifying and correcting individual or system errors, and we examine whether the institution's medical system mitigated the error. The OIG rates each applicable indicator ***proficient***, ***adequate***, or ***inadequate,*** and considers each rating in the overall conclusion of the institution's health care performance.

In contrast to Cycle 6, the OIG will provide individual clinical case review ratings and compliance testing scores in Cycle 7, rather than aggregate all findings into a single overall institution rating. This change will clarify the distinctions between these differing quality measures and the results of each assessment.

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of California Health

[1] In this report, we use the terms *patient* and *patients* to refer to *incarcerated people*.

[2] The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

[3] In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for comparison purposes.

Care Facility, the institution had not been delegated back to the department by the receiver.

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from July 2024 to December 2024.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between January 2024 and October 2024.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of California Health Care Facility (CHCF) in August 2025. OIG inspectors monitored the institution's delivery of medical care that occurred between July 2024 and December 2024.

The OIG rated the case review component of the overall health care quality at CHCF ***inadequate***.

The OIG rated the compliance component of the overall health care quality at CHCF ***inadequate***.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 67 cases, which contained 2,222 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes, which may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in August 2025 to verify their initial findings. The OIG physicians rated the quality of care for 31 comprehensive case reviews. Of these 31 cases, our physicians rated 26 ***adequate,*** five ***inadequate***, and none ***proficient***.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 361 patient records and 1,609 data points, and we used the data to answer 91 policy questions. In addition, we observed CHCF's processes during an on-site inspection in February 2025.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in 13 health care indicators.[5]

[5] The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to CHCF.

We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. CHCF Summary Table: Case Review Ratings and Policy Compliance Scores

		Ratings: Proficient / Adequate / Inadequate		Scoring Ranges: 100%–85.0% / 84.9%–75.0% / 74.9%–0		
		Case Review		Compliance		
MIT Number	Health Care Indicators	Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*
1	Access to Care	Adequate	=	76.7%	80.3%	=
2	Diagnostic Services	Adequate	=	57.5%	51.7%	=
3	Emergency Services	Inadequate	↑	N/A	N/A	N/A
4	Health Information Management	Adequate	↑	90.1%	74.3%	↑↑
5	Health Care Environment†	N/A	N/A	55.6%	49.3%	=
6	Transfers	Adequate	=	58.7%	84.3%	↓
7	Medication Management	Adequate	↑	70.1%	50.8%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	98.2%	78.2%	↑
10	Nursing Performance	Inadequate	=	N/A	N/A	N/A
11	Provider Performance	Adequate	↑	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Inadequate	=	74.3%	79.7%	↓
14	Specialty Services	Inadequate	=	64.8%	62.2%	=
15	Administrative Operations†	N/A	N/A	61.7%	72.7%	=

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 6 and Cycle 7. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Health Care Environment** and **Administrative Operations** are secondary indicators and are not considered when rating the institution's overall medical quality.

Source: The Office of the Inspector General medical inspection results.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[6]

The OIG found no adverse events at CHCF during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to CHCF. Of these 10 indicators, OIG clinicians rated none ***proficient***, six ***adequate***, and four ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 31 detailed case reviews they conducted. Of these 31 cases, none were ***proficient***, 26 were ***adequate***, and five were ***inadequate***. In the 2,222 events reviewed, we identified 769 deficiencies, 162 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at CHCF:

- Patients received good access to providers and nurses.
- Staff often completed laboratory and radiology testing within required time frames.
- Nurses ensured medication continuity was maintained for patients who transferred in and out of the facility.
- The providers showed good clinical decision-making and addressed most of their patients' chronic medical conditions appropriately.

Our clinicians found the following weaknesses at CHCF:

- Providers did not consistently communicate results to patients with complete test result notification letters.
- Staff needed improvement in completing STAT laboratory testing timely.
- Nurses frequently did not contact the hospital to request immediate recommendations for patients returning from a hospitalization.

[6] For a further discussion of an adverse event, see Table A–1.

- Providers struggled with sufficiently managing their patients on chronic anticoagulation with warfarin.[7]
- Providers needed improvement in documenting vital signs or pertinent physical examinations for their patients.
- Many specialty access appointments did not occur within requested time frames.
- The institution needed improvement in ensuring patients in specialized medical housing who returned from a hospitalization receive their hospital return medications timely.
- Nursing staff in the specialized medical housing needed improvement in completing thorough admission and wound assessments and providing emergency care, specifically initiating 911 without delays.
- Healthcare leadership needed improvement in ensuring clinical reviews of urgent emergent events are completed timely and thoroughly

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to CHCF. Of these 10 indicators, our compliance inspectors rated two ***proficient***, one ***adequate***, and seven ***inadequate***. We solely tested policy compliance in **Health Care Environment**, **Preventive Services**, and **Administrative Operations** as these indicators do not have a case review component.

CHCF showed a high rate of policy compliance in the following areas:

- Staff timely scanned non-dictated progress notes, initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records.
- Staff performed well in offering immunizations and providing preventive services for their patients, such as influenza vaccination, annual testing for tuberculosis (TB), and colorectal cancer screenings.

CHCF revealed a low rate of policy compliance in the following areas:

- Providers often did not communicate results of diagnostic services timely with complete test result notification letters.
- Patients frequently did not receive their ordered chronic care medications, hospital discharge medications, and newly ordered medications within the specified time frames.

[7] Warfarin also called Coumadin is a blood thinning medication. INR a blood test that monitors the effects of Coumadin.

- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.
- Nurses did not regularly inspect emergency medical response bags. In addition, medical treatment carts were missing the minimum level of supplies during random inspections.

Institution-Specific Metrics

California Health Care Facility is a 54-building complex located in South Stockton. The facility offers housing and treatment for 2,951 incarcerated person-patients, which are provided by a professional health care staff of 2,500. CHCF provides medical care and mental health treatment to incarcerated people who have the most severe and long-term needs. The 1.4 million square foot facility is certified to provide intermediate level care and to complement less acute treatment provided in other prisons operated by the department. This facility provides both outpatient and inpatient mental health services for patients with mental health disorders. The licensed psychiatric inpatient program at this facility is designed to provide more intensive treatment for patients who cannot function adequately or stabilize in an outpatient program. CHCF has a correctional treatment center (CTC) for inpatient services, an outpatient housing unit (OHU), a clinic for dialysis, and beds for mental health crisis treatment. CHCF has been designated an *intermediate care prison*; these institutions are predominately located in urban areas, close to medical centers and specialty care providers who are likely to be used by a patient population with higher medical needs.

As of February 2, 2026, the department reported on its public tracker 82 percent of CHCF's incarcerated population was fully vaccinated for COVID-19 while 74 percent of CHCF's staff was fully vaccinated for COVID-19.[8]

On February 3, 2025, the Health Care Services Master Registry showed CHCF had a total population of 2,123. A breakdown of the medical risk level of the CHCF population as determined by the department is set forth in Table 2 below.[9]

Table 2. CHCF Master Registry Data as of February 2025

Medical Risk Level	Number of Patients	Percentage*
High 1	1,137	53.6%
High 2	449	21.1%
Medium	397	18.7%
Low	140	6.6%
Total	**2,123**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated February 3, 2025.

[8] For more information, see the department's statistics on its website page titled **Population COVID-19 Tracking**.

[9] For a definition of *medical risk*, see CCHCS HCDOM 1.2.14, Appendix 1.9.

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, CHCF had no vacant executive leadership positions, 29.7 nursing supervisor vacancies, 92.7 nursing staff vacancies, and a surplus of 1.9 primary care providers.

Table 3. CHCF Health Care Staffing Resources as of August 2025

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	8	32.1	156.7	1,558.3	1,785.1
Filled by Civil Service	8	34.0	127.0	1,495.6	1,664.6
Vacant	0	-1.9	29.7	92.7	120.5
Percentage Filled by Civil Service	100.0%	105.9%	81.0%	94.2%	93.2%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	1.3	0	18.5	19.8
Percentage Filled by Registry	0	4.0%	0	1.2%	1.1%
Total Filled Positions	8.0	35.3	127.0	1,514.1	1,684.4
Total Percentage Filled	**100.0%**	**110.0%**	**81.0%**	**95.3%**	**94.4%**
Appointments in Last 12 Months	1.0	0	28.0	29.0	58.0
Redirected Staff	2.0	0	1.0	0	3.0
Staff on Extended Leave ‡	0	0	2.0	15.0	17.0
Adjusted Total: Filled Positions	**6.0**	**35.3**	**124.0**	**1,499.1**	**1,664.4**
Adjusted Total: Percentage Filled	**75.0%**	**110.0%**	**79.1%**	**94.4%**	**93.2%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes the classifications of Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time-base equivalents.

Source: Cycle 7 medical inspection preinspection questionnaire received on August 14, 2025, from California Correctional Health Care Services.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 7. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report,* the OIG obtained California Medi-Cal and Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered CHCF's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only two HEDIS measures are available for review: **poor HbA1c control**, which measures the percentage of diabetic patients who have poor blood sugar control, and **colorectal cancer screening rates** for patients ages 45 to 75. We list the applicable HEDIS measures in Table 4.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)— CHCF's percentage of patients with poor HbA1c control was significantly lower, indicating very good performance on this measure.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. CHCF had a 60 percent influenza immunization rate for adults 18 to 64 years old and a 78 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccination rate was 90 percent.[11]

Cancer Screening

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)— CHCF's colorectal cancer screening rate was 95 percent, indicating very good performance on this measure.

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[10] The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result.

[11] The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV15, and PCV20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than where the patient was currently housed during the inspection period.

Table 4. CHCF Results Compared With State HEDIS Scores

HEDIS Measure	CHCF Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**8%**	33%	26%	19%
HbA1c Control (< 8.0%) ‡	83%	–	–	–
Blood Pressure Control (< 140/90) ‡	91%	–	–	–
Eye Examinations	65%	–	–	–
Influenza – Adults (18–64)	60%	–	–	–
Influenza – Adults (65+)	78%	–	–	–
Pneumococcal – Adults (65+)	90%	–	–	–
Colorectal Cancer Screening	**95%**	40%	71%	71%

Notes and Sources

* Unless otherwise stated, data were collected in February 2024 by reviewing medical records from a sample of CHCF's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2023–June 30, 2024 (published April 2025); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2023-24-Medi-Cal-Managed-Care-Physical-Health-External-Quality-Review-Technical-Report-Vol1-F1.pdf**.

‡ For this indicator, the entire applicable CHCF population was tested.

§ For this measure only, a lower score is better.

Source: Institution information provided by the California Department of Corrections and Rehabilitation. Health care plan data were obtained from the CCHCS Master Registry.

Recommendations

As a result of our assessment of CHCF's performance, we offer the following recommendations to the department:

Diagnostic Services

- The department should develop and implement strategies, such as an electronic solution, to ensure that providers create patient letters at the time of endorsement and the patient results letter automatically populates accurately with all required elements per CCHCS policy.

- Medical leadership should determine the root cause(s) of challenges to notification and endorsement of STAT laboratory results and should implement remedial measures as appropriate to ensure STAT laboratory tests are performed within required time frames.

Emergency Services

- Healthcare leadership should develop strategies to ensure clinical reviews of urgent emergent events are completed timely and thoroughly as well as identify staff training issues.

- The Emergency Medical Response Review Committee (EMRRC) should develop and implement strategies to ensure the EMRRC thoroughly reviews emergency response events within the required time frame, and the CME and CNE review emergency events as required.

- Nursing leadership should determine the challenges for nurses in providing appropriate and timely interventions and should provide remedial measures as appropriate.

- Leadership should develop and implement strategies to ensure all staff activate the 9-1-1 system immediately for emergent patients needing a higher level of care.

Health Care Environment

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs, treatment carts, and urgent carts are regularly inventoried and sealed and should implement remedial measures as appropriate.

Transfers

- Nursing leadership should identify the challenges for nursing staff in obtaining hospital recommendations for patients upon return to the institution from hospitalizations and emergency room encounters. Leadership should implement remedial measures as appropriate.

- Nursing leadership should develop strategies to ensure nursing staff completely answer and address required initial health screening questions. Leadership should implement remedial measures as appropriate.

Medication Management

- Medical and nursing leadership should determine the challenges to ensuring chronic care patients, hospital discharge patients, and patients admitted to specialized medical housing receive their medications timely and without interruption. Leadership should implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from performing complete assessments, initiating provider follow-up appointments when warranted, and providing appropriate patient education. Leadership should implement remedial measures as appropriate, including training staff as needed.

- Nursing leadership should develop and implement strategies to ensure CTC nurses complete documentation of wound care assessments including clinical appearance of the wound, surrounding tissue, and measurements.

Provider Performance

- Medical leadership should identify the root cause(s) for the poor management of patients on warfarin and implement remedial measures as appropriate.

- Medical leadership identify the root cause(s) for providers not documenting pertinent vital signs and pertinent physical examinations and implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should determine the challenges preventing SMH nurses from completing thorough assessments to include admission assessments, wound care, PICC line care, and notifying the RN or provider for any abnormal changes in patient condition as well as documenting accurately. Leadership should implement remedial measures as appropriate.

- Leadership should develop and implement strategies to ensure all staff activate the 9-1-1 system immediately for emergent patients needing a higher level of care.

- Nursing leadership should determine the root cause of challenges to SMH patients receiving all ordered medications within the required time frame and should implement remedial measures as appropriate.

Specialty Services

- Medical leadership should determine the root cause(s) of challenges to staff timely providing initial specialty appointments and their subsequent follow-up appointments and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) of challenges for staff timely retrieving and scanning specialty reports, as well as providers timely endorsing specialty reports, and should implement necessary remedial measures.

Access to Care

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed scheduling and appointment timeliness for newly arrived patients, sick calls, and nurse follow-up appointments. We examined referrals to primary care providers, provider follow-ups, and specialists. Furthermore, we evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (76.7%)**

In this cycle, like in Cycle 6, case review found CHCF provided very good access to care. Patients received excellent access to providers and nurses. However, we identified significant specialty service appointment deficiencies. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed CHCF's performance was satisfactory in this indicator. Nursing staff often timely reviewed patient sick call requests and completed face-to-face triage. Timely provider appointments usually occurred for newly transferred patients, chronic care patients, patients returning after specialty service appointments, and patients returning after hospitalizations. However, access to specialty services needed improvement. Based on the overall **Access to Care** compliance score result, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 511 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events requiring the institution to generate appointments. We identified 34 deficiencies related to access to care, 23 of which were significant.[12]

Access to Care Providers

CHCF performed variably with timely provider access for patients. Compliance testing showed good access to chronic care follow-up appointments (MIT 1.001, 84.0%) and satisfactory access to nurse-to-provider sick call referrals (MIT 1.005, 76.5%). However, timely completion of provider sick call follow-up appointments needed improvement (MIT 1.006, 50.0%). OIG clinicians found CHCF timely completed almost all provider appointments and identified only two deficiencies, both of which were significant:

- In case 23, the nurse assessed the patient for complaints of right eye discomfort following cataract surgery. The nurse scheduled the patient for a

[12] Access to care deficiencies occurred in cases 1- 4, 5, 12, 18-20, 22, 23, 27, 29, 33-35, and 36. Severe deficiencies occurred in cases 1-5, 18-20, 22, 23, 27, 29, 33-35, and 36.

provider follow-up appointment to occur within 14 days. However, the appointment did not occur as scheduled with the documented reason "PCP is off."

- In case 36, the patient underwent a high-priority ultrasound procedure on site. However, the required five-day follow-up appointment with the CHCF provider did not occur.

Access to Specialized Medical Housing Providers

CHCF performed well with access to specialized medical housing providers. Compliance showed providers usually completed history and physical examinations timely (MIT 13.002, 81.8%). OIG clinicians found excellent access to specialized medical housing providers and identified only four deficiencies.[13] The following deficiencies were significant:

- In case 1, staff informed the provider of the patient's extremely elevated blood pressure along with a plan for medication administration and a provider follow-up evaluation the next day. However, this evaluation did not occur.

- Also in case 1, the patient complained of fatigue and shortness of breath but refused transfer to a higher level of care. The provider documented for the patient to have a "PCP follow-up." However, this evaluation did not occur.

- In case 4, the patient received intravenous fluids for symptomatic low blood pressure, and the provider documented a plan for provider follow-up the next day. However, this evaluation did not occur.

Access to Clinic Nurses

CHCF performed very well with access to nurses. Compliance testing showed registered nurses generally reviewed patients' requests for services the same day they were submitted (MIT 1.003, 83.3%). Similarly, nurses almost always completed face-to-face appointments within one business day following sick call request reviews (MIT 1.004, 92.9%). OIG clinicians reviewed sick call requests in 31 cases and identified two deficiencies related to clinic nurse access, one of which was significant: [14]

- In case 22, the sick call nurse assessed the patient, who requested an eye examination. The patient reported blurry vision, and the nurse documented "RN follow-up within 14 calendar days." However, the nurse follow-up appointment did not occur.

[13] Specialized medical housing access deficiencies occurred in cases 1, 4, and 20. Significant deficiencies occurred in cases 1 and 4.

[14] Nurse access deficiencies occurred in cases 22 and 33. A significant deficiency occurred in case 22.

Access to Specialty Services

CHCF inconsistently completed specialty service appointments timely. Although compliance testing showed satisfactory completion of high-priority (MIT 14.001, 80.0%) appointments, completion of routine-priority (MIT 14.007, 73.3%) and medium-priority (MIT 14.004, 66.7%) appointments needed improvement. Similarly, compliance testing also revealed completing subsequent high-priority (MIT 14.003, 66.7%), routine-priority (MIT 14.009, 66.7%), and medium-priority (MIT 14.006, 50.0%) follow-up specialty service appointments only sometimes occurred. Compliance testing showed completion of pre-approved specialty service appointments following transfer was poor (MIT 14.010, 50.0%). OIG clinicians found specialty appointments usually occurred within requested time frames; however, we identified 17 deficiencies.[15] Of these 17 deficiencies, we identified 14 significant deficiencies.[16] The following are examples:

- In case 18, the provider ordered a vascular surgery specialty appointment; however, the appointment occurred over a month late.
- In case 19, the patient's high-priority hand surgery specialty appointment occurred 33 days late.
- In case 22, the provider ordered an ENT specialty appointment, which occurred over five months late.[17]
- In case 36, a general surgeon evaluated the patient for an axillary mass at an appointment that was five weeks late.

We discuss this further in the **Specialty Services** indicator.

Follow-Up After Specialty Services

Compliance testing showed provider appointments after specialty services generally occurred within required time frames (MIT 1.008, 79.1%). Similarly, OIG clinicians identified only two deficiencies, one of which was significant.[18]

We discuss this further in the **Specialty Services** indicator.

Follow-Up After Hospitalization

Follow-up provider appointments after hospitalizations generally occurred timely. Compliance testing showed satisfactory completion of post-hospitalization provider appointments within required time frames (MIT 1.007, 82.6%). OIG clinicians identified only two deficiencies, both of which were significant:

- In case 5, the patient returned to CHCF following an emergency room evaluation for chest pain. The nurse entered a communication order for a medical higher level of care follow-up appointment with a CHCF provider,

[15] Deficiencies occurred in cases 3, 12, 18-20, 22, 27, 29, 33, 35, and 36.

[16] Significant deficiencies occurred in cases 3, 18-20, 22, 27, 29, 33, 35, and 36.

[17] An ENT specialist is an Ear Nose and Throat specialist.

[18] Deficiencies occurred in cases 2 and 36. A significant deficiency occurred in case 2.

which should have taken place within five days. However, the provider evaluated the patient six days beyond the deadline.

- In case 34, the patient returned from the emergency department after sustaining a left-hand fracture. However, the required five-day provider follow-up appointment with the patient did not occur.

Follow-Up After Urgent or Emergent Care (TTA)

Providers always evaluated their patients following a triage and treatment area (TTA) event as medically indicated. OIG clinicians reviewed 70 TTA events and identified no delays in provider follow-up appointments.

Follow-Up After Transferring Into the CHCF

Access to care for patients who had recently transferred into the institution was mixed. Compliance testing showed very good access for intake appointments of newly arrived patients (MIT 1.002, 92.0%). OIG clinicians found no deficiencies in the six cases reviewed for intake appointment access.

We discuss this further in the **Transfers** indicator.

Clinician On-Site Inspection

CHCF had five main clinical care yards: A, B, C, D, and E. The A yard clinic serviced mental health and the permanent work crew (PWC), while the B yard clinic supported psychiatric inpatient program (PIP) patients. The C yard clinic was the designated outpatient housing unit (OHU) and contained six sub-units designated as either "A" or "B" side. Similarly, the D yard clinic housed the clinical treatment center (CTC) and contained seven sub-units also designated as "A" or "B" side. The D7A was the palliative care center while the D7B was the memory care center. The E yard clinic was the outpatient clinic and provided care to the restricted housing unit (RHU) and general population.

The OIG clinicians attended the OHU, CTC, and clinic huddles, which were well attended by the patient care team and staff. Staff participated in the meeting either in person or via video conferencing. During the morning provider meeting, management reviewed new policy changes for patient care as directed by headquarters or guided by local operating procedures. For the huddles in the OHU and CTC, the nurses and providers, along with custody staff, discussed any new patient concerns, medication refusals, upcoming specialty service consultations and procedures, and the overall plans of care. The providers, nurses, and licensed vocational nurses displayed an in-depth understanding of their patients and collaborated with custody staff as needed.

OIG clinicians spoke with the assistant chief nurse executive (CNE) and SRN III regarding CHCF's care access. At the time of the on-site inspection, they reported having 141 staff vacancies in July 2025, which decreased in comparison to July 2024 with 400 vacancies. The classifications most impacted with vacancies were the registered nurse and certified nursing assistant positions. They cited advertising as contributing to mass hiring during the months of September 2024 and January 2025.

Compliance Score Results

Table 5. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	21	4	0	84.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	23	2	0	92.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	25	5	0	83.3%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	26	2	2	92.9%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	13	4	13	76.5%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	1	1	28	50.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	19	4	0	82.6%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	34	9	2	79.1%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
				Overall percentage (MIT 1): 76.7%

* CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Table 6. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	18	4	0	81.8%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	6	3	6	66.7%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	2	2	11	50.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	4	2	9	66.7%

Source: The Office of the Inspector General medical inspection results.

Recommendations

The OIG offers no recommendations for this indicator.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (57.5%)**

Case review found CHCF performed satisfactorily with diagnostic services. Staff generally completed laboratory and radiology tests timely. However, we identified a pattern of late provider endorsements of laboratory test results. While providers usually communicated radiology, laboratory, and pathology results to their patients through patient notification letters, they often sent incomplete letters or did not send letters at all. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

CHCF compliance testing scored low overall for this indicator. Staff always received pathology reports timely, and providers almost always endorsed STAT laboratory results within required time frames. Staff frequently completed radiology and laboratory services timely, and providers often promptly endorsed radiology and pathology results. However, CHCF staff needed improvement in timely completing STAT laboratory services, and providers needed significant improvement in generating complete patient test results notification letters with all required elements. Based on the overall **Diagnostic Services** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 490 diagnostic-related events and identified 256 deficiencies, 23 of which were significant.[19] Of the 256 deficiencies, 251 related to health information management and five related to delayed completion of ordered tests. Of the health information management deficiencies, 194 related to providers not sending letters, providers sending letters late, or letters missing some of the required elements, and 50 deficiencies were due to delayed endorsement of laboratory tests. Although we identified a high number of these deficiencies, we attributed this to the high number of tests performed and determined these deficiencies did not significantly increase the risk of harm to patients.

[19] Deficiencies occurred in cases 1-5 and 11-36. Significant deficiencies occurred in cases 1, 12, 16, 18, 26, 27, and 30.

Test Completion

CHCF performed sufficiently in completing tests timely. Compliance testing showed satisfactory performance in completing radiology services (MIT 2.001, 80.0%) and laboratory tests (MIT 2.004, 80.0%) within required time frames. However, compliance testing revealed staff performed poorly in timely completing STAT laboratory services (MIT 2.007, 50.0%). OIG clinicians identified five deficiencies related to diagnostic test completion, one of which included STAT laboratory testing. The following are examples:

- In case 18, the provider ordered a STAT INR blood test. However, the result was not available until more than four hours later.[20]
- In case 34, laboratory staff completed a fecal immunochemical test (FIT) seven days late.[21]

Health Information Management

CHCF performed variably in managing the results of diagnostic tests. Compliance testing showed providers generally endorsed radiology results timely (MIT 2.002, 80.0%) but needed improvement for endorsing laboratory results timely (MIT 2.005, 60.0%). OIG clinicians identified a pattern of 50 deficiencies related to the late endorsement of test results.[22] The following are examples:

- In case 12, the provider endorsed a blood test eight days late.
- In case 16, the provider endorsed an INR test result 15 days late.
- In case 18, the provider endorsed an INR test result 22 days late.

In compliance testing, staff performed excellently in timely retrieving pathology reports (MIT 2.010, 100%). Additionally, providers performed well with timely communicating STAT laboratory results (MIT 2.009, 90.0%) and timely reviewing pathology reports (MIT 2.011, 80.0%). However, compliance testing revealed providers performed poorly with reviewing STAT laboratory test results timely (MIT 2.008, 30.0%). In contrast, OIG clinicians did not identify any deficiencies related to STAT or pathology test result retrieval or provider review.

Compliance testing revealed CHCF providers performed poorly with communicating test results to their patients with complete notification letters. Providers rarely communicated to patients with complete notification letters of results from radiology (MIT 2.003, 10.0%) and laboratory (MIT 2.006, 30.0%) studies within the required time frames. Furthermore, providers never communicated pathology results to patients with patient notification letters (MIT 2.012, zero). OIG clinicians similarly identified 194

[20] INR, International Normalized Ratio, is a laboratory test to measure the body's blood clotting. This test is used to monitor the effectiveness of blood thinning medications such as warfarin. Per the HCDOM 3.1.14.c.2.H, "STAT results shall be provided by the contracted laboratory via telephone to the Triage and Treatment Area (TTA), or designated health care team member, within four hours of the telephone request for pick-up for non-rural institutions."

[21] The FIT test is used to screen for colorectal cancer.

[22] Deficiencies occurred in cases 1, 2, 4, 12, 14, 16-18, 22, 26, 27, 29-34, and 36.

deficiencies related to providers sending incomplete patient test notification letters or not sending letters to the patient.[23]

Additional discussion can be found under the **Health Information Management** indicator.

Clinician On-Site Inspection

OIG clinicians interviewed the chief support executive (CSE) and the correctional health services administrator (CHSA), who reported the institution experienced diagnostic staff shortages during the review period. CHCF had three laboratory technician vacancies and one senior radiology technician on medical leave. The laboratory technician vacancies resulted in laboratory technicians cross covering different areas of the facility, causing a minor backlog of test collection. CHCF reported recently filing their vacancies to ensure complete staffing before our on-site inspection. Since filing the vacancies, leadership reported no current backlog of radiology or laboratory appointments

CHCF offers x-ray, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, and FibroScans on-site.[24] The CHSA reported no appointment backlog in diagnostic studies. The providers did not report any problems with obtaining laboratory or imaging studies on-site; however, they mentioned occasional difficulties with obtaining off-site radiology reports. The providers did not experience any issues with obtaining STAT laboratory results and stated the SEMS provider would receive STAT laboratory results after hours and intervene when needed.[25]

[23] Deficiencies in patient notification letters occurred in cases 1-5 and 11-36. None of these deficiencies were significant.

[24] A CT is a computed, or computerized, tomography scan while an MRI is a magnetic resonance imaging scan. Both create detailed images of the organs and tissues to detect diseases and abnormalities. A FibroScan is a diagnostic imaging scan used to evaluate for liver scarring and fatty changes from liver disease.

[25] SEMS is the licensed standby emergency medical services unit with staff to manage urgent and emergent care for patients.

Compliance Score Results

Table 7. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	8	2	0	80.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	8	2	0	80.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	1	9	0	10.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	6	4	0	60.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	3	7	0	30.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	5	5	0	50.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	3	7	0	30.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	9	1	0	90.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): 57.5%

Source: The Office of the Inspector General medical inspection results.

Recommendations

- The department should develop and implement strategies, such as an electronic solution, to ensure that providers create patient letters at the time of endorsement and the patient results letter automatically populates accurately with all required elements per CCHCS policy.

- Medical leadership should determine the root cause(s) of challenges to notification and endorsement of STAT laboratory results and should implement remedial measures as appropriate to ensure STAT laboratory tests are performed within required time frames.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. We reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, standby emergency medical services (SEMS), provider performance, and nursing performance.[26] OIG clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) performance in identifying problems with its emergency services. The OIG assessed the institution's emergency services solely through case review.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Not Applicable***

Case review found CHCF's emergency services needs improvement. Many of the medical emergencies occurred in the Specialized Medical Housing (SMH) unit. The SEMS staff responded to medical emergencies promptly. Generally, CHCF providers made appropriate decisions and performed well in urgent and emergent situations and in after-hours care. Similarly, the SEMS nurses mostly performed satisfactory assessments and documentation. However, we found opportunities for improvement with timely and appropriate interventions. We identified delays in SMH staff calling 9-1-1. In addition, CHCF performed poorly with clinical reviews of medical emergency events. Considering all factors, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 70 urgent and emergent events and found 93 emergency care deficiencies. Of these 93 deficiencies, 20 were significant.[27]

Emergency Medical Response

We reviewed 45 events requiring a medical emergency response from SEMS. CHCF nurses notified SEMS timely, and SEMS nursing staff responded promptly to emergencies throughout the institution. However, we found SMH staff needed improvement in providing emergency care, most commonly in initiating 9-1-1 without delays. OIG clinicians identified seven deficiencies in five cases in which SMH nurses did not initiate 9-1-1 timely.[28] The following are examples:

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[26] At CHCF, the Standby Emergency Medical Services (SEMS) is the medical area normally called the Triage and Treatment Area (TTA) at other CCHCS institutions. The TTA or SEMS area is where an institution's medical staff provide urgent and emergent care to patients.

[27] Deficiencies occurred in cases 1-15, and 27-31. Significant deficiencies occurred in case 1, 4-6, 10, 12, 13, and 15.

[28] Deficiencies with delays in contacting 9-1-1 occurred in case 1, 4, 5, 12, and 15.

- In case 4, we identified a delay in calling 9-1-1. The OHU nurse assessed the patient as having "stroke-like" symptoms but did not call 9-1-1 until five minutes later.

- In case 5, the CTC nurse assessed the patient as having an altered level of consciousness and activated a medical emergency alarm, but the nurse did not call 9-1-1 until 13 minutes later. On another occasion in case 5, the patient complained of chest pain. The CTC nurse assessed the patient, notified the provider, activated a medical emergency, and called 9-1-1; however, we identified a six-minute delay in calling 9-1-1.

- On a separate event in case 5, the CTC patient had an unwitnessed fall and complained of head, back, and neck pain. The nurse documented an assessment but did not apply a cervical collar to prevent any further injury. Additionally, the assessment notes indicated the nurse assisted the patient to sit up despite the patient's complaints.

- In case 12, the OHU patient complained of left-side chest pain with dizziness, but staff delayed calling 9-1-1 for 19 minutes.

- In case 13, the CTC nursing staff found the patient unresponsive in his cell and initiated CPR. However, the nurse did not apply an automated external defibrillator (AED) on the patient, and the nurse inappropriately applied a non-rebreather mask instead of providing positive pressure ventilation via an Ambu bag.[29]

Cardiopulmonary Resuscitation Quality

CHCF staff displayed satisfactory performance in this area. The OIG clinicians reviewed seven cases in which patients required cardiopulmonary resuscitation (CPR).[30] CHCF staff assessed the patients and initiated CPR promptly. However, we identified the following deficiencies:

- In case 6, the nursing staff responded to an unresponsive patient and initiated CPR. However, staff delayed in applying the AED for six minutes.

- In case 10, the nurse activated a personal alarm for a medical emergency for an unresponsive patient with no pulse or respirations and initiated CPR. However, staff delayed administering Naloxone to the patient, who was suspected to have a drug overdose, for six minutes.

Provider Performance

CHCF providers performed well overall in urgent and emergent situations and in after-hours care. The institution provided emergency coverage within SEMS in addition to the specific housing units. OIG clinicians identified a minor pattern of providers not

[29] Automated External Defibrillator (AED) is a portable device that can analyze and deliver an electrical shock to patients with cardiac arrest. A non-rebreather mask is an oxygen mask that delivers high concentrations of oxygen and is used when person can breathe on their own but needs a lot of oxygen quicky. An Ambu bag delivers a higher amount of oxygenation to the patient when they cannot breathe on their own.

[30] Deficiencies occurred in cases 6, 7, 9, 10, and 13. Significant deficiencies occurred in cases 6, 10, and 13.

documenting progress notes for patients who were transferred to a higher level of care. We identified five instances in which the provider did not document a progress note for an emergent event, but we determined this did not significantly impact care. CHCF providers made appropriate decisions for patients who were transferred to a higher level of care. Additionally, providers usually transferred patients to a higher level of care through the appropriate mode of transportation. However, we identified two instances of inadequate medical decision making within an emergent event:

- In case 15, the patient presented with a low blood pressure requiring transfer to the emergency room. However, the provider did not document a differential diagnosis for the patient's symptoms, which could have affected the patient's treatment plan.

- In case 34, the nurse informed the provider of a patient experiencing chest pain, with a history of hypertension, hyperlipidemia, and diabetes. The provider ordered a gastrointestinal cocktail medication but did not document a progress note or consider acute coronary syndrome as an etiology for the patient's symptoms.

Nursing Performance

Overall, SEMS nurses performed satisfactory patient assessments, but with opportunities for improvement as we found in a few cases with missing components of the nursing assessments.[31] The following is an example:

- In case 14, the SEMS nurse responded to E facility for a patient with right inguinal hernia bulging with moderate pain. The SEMS nurse assumed care of the patient, transported the patient back to SEMS, and assessed the patient. However, the SEMS nurse did not perform an abdominal assessment to include listening to bowel sounds, assessing abdominal distention and tenderness, and the nurse did not reassess the patient's level of pain or document last bowel movement. Additionally, the nurse did not obtain vital signs.

Nursing Documentation

SEMS nurses showed satisfactory performance with opportunities for improvement for documentation.[32] Examples of documentation deficiencies included: not documenting medication administration on the medication administration record, not documenting EMS arrival and departure times, and documenting occurrences of assessing vital signs after documenting the patient had left the facility. These deficiencies did not affect overall patient care.

Emergency Medical Response Review Committee

Clinical reviews for medical emergency events are necessary to identify opportunities for improvement with interdisciplinary staff performance, identify and correct system issues, and provide any necessary staff training. OIG clinicians reviewed 41 events that required

[31] Assessment deficiencies occurred in cases 1, 4, 5, 7, 12, 14, 28, 30, and 31.

[32] Documentation deficiencies occurred in cases 1, 4, 5, 7-12, 14, 15, 27, 29, and 30.

the institution to perform a clinical review, and we identified 39 deficiencies. OIG clinicians found a pattern in which the chief medical executive (CME) and chief nurse executive (CNE) did not perform clinical reviews of emergency events. In addition, we identified eight significant deficiencies the reviewing supervising registered nurse (SRN) did not identify.[33] The following are examples:

- In case 5, the SRN performed a clinical review of the patient with an altered level of consciousness but did not identify as a corrective issue that the CTC nurse delayed calling 9-1-1 for 13 minutes.

- In case 12, the SRN performed a clinical review for the patient reporting chest pain and dizziness. The SRN did not identify as a corrective issue that staff delayed calling 9-1-1 for 19 minutes.

- In case 13, the SRN performed a clinical review for the unresponsive patient, who required CPR. The SRN did not identify as corrective issues that the nurse did not apply an AED on the patient, and the nurse inappropriately applied a non-rebreather mask instead of providing positive pressure ventilation via an Ambu Bag.

Compliance testing showed the EMRRC only sporadically completed timely reviews, and a few had incomplete checklists (MIT 15.003, 16.7%). We discuss this further in the **Administrative Operations** indicator.

Clinician On-Site Inspection

OIG clinicians toured the SEMS and interviewed the nursing staff and SRN. The SEMS nursing staff informed us each shift has three RNs, two LVNs, and a regular provider assigned to SEMS. The staff informed us the emergency medical response program had not yet been fully implemented at the time of our on-site inspection.

The SEMS had four emergency vehicles and six beds. Four of the beds had cardiac monitors. Custody staff used one vehicle to respond to emergencies with the SEMS staff. The nursing staff reported no issues with pharmacy or equipment but did report experiencing challenges with supplies. When the housing units had supplies on back order, the housing unit staff would come to the SEMS to obtain the needed supplies. The nursing staff described their administration as supportive, custody staff as helpful, and stated the nursing morale was fair.

[33] The SRN did not identify deficiencies the OIG clinicians identified in cases 1, 4-6, 7, 9, 10, 12, and 28-30. Significant deficiencies occurred in cases 1, 5-7, 12, and 13.

Recommendations

- Healthcare leadership should develop strategies to ensure clinical reviews of urgent emergent events are completed timely and thoroughly as well as identify staff training issues.
- The Emergency Medical Response Review Committee (EMRRC) should develop and implement strategies to ensure the EMRRC thoroughly reviews emergency response events within the required time frame, and the CME and CNE review emergency events as required.
- Nursing leadership should determine the challenges for nurses in providing appropriate and timely interventions and should provide remedial measures as appropriate.
- Leadership should develop and implement strategies to ensure all staff activate the 9-1-1 system immediately for emergent patients needing a higher level of care.

Health Information Management

In this indicator, OIG inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. Our inspectors examined whether the institution retrieved and scanned critical health information (progress notes, diagnostic reports, specialist reports, and hospital discharge reports) into the medical record in a timely manner. Our inspectors also tested whether clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Proficient*** **(90.1%)**

Case review found CHCF improved from Cycle 6. Staff performed well with scanning hospital records into patients' electronic health records. Providers usually endorsed laboratory results timely. However, we identified a large number of deficiencies related to specialty reports. Additionally, providers frequently generated patient notification diagnostic test result letters without all elements required per CCHCS policy. After careful consideration of all findings, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed CHCF performed very well in health information management. Staff always timely scanned patient sick call requests and hospital discharge documents and almost always timely scanned specialty reports into the EHRS.[34] In addition, providers frequently endorsed and reviewed hospitalization discharge reports within required time frames. However, staff inconsistently labeled and scanned medical records into the correct patient files. Based on the overall **Health Information Management** compliance score result, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 2,222 events and identified 304 deficiencies related to health information management, 42 of which were significant.[35]

Hospital Discharge Reports

CHCF staff always handled hospital discharge reports timely. Compliance testing found CHCF staff always retrieved, scanned, and reviewed hospital discharge records within the required time frames (MIT 4.003, 100%). OIG clinicians reviewed 251 off-site

[34] EHRS is the Electronic Health Records System. The department's electronic health record system is used for storing the patient's medical history. The health care staff use the system to communicate. This record stays with the patient throughout the patient's time in department's correctional system.

[35] Deficiencies occurred in cases 1-5 and 11-36. Significant deficiencies occurred in cases 1-3, 5, 11, 12, 15, 16, 18, 21, 22, 26-28, 30, 31, 33, and 34.

emergency department and hospital encounters and did not identify any deficiencies with retrieving or scanning into the EHRS.

Specialty Reports

CHCF staff performed variably in managing specialty reports. Compliance testing showed excellent timely retrieval of specialty reports (MIT 4.002, 96.7%). However, providers needed improvement in timely endorsing high-priority (MIT 14.002, 66.7%) and routine-priority (MIT 14.008, 66.7%) specialty reports. Providers performed poorly in endorsing medium-priority (MIT 14.005, 40.0%) specialty reports timely.

OIG clinicians reviewed 235 specialty reports and identified 46 deficiencies, 21 of which were significant.[36] Of the 21 deficiencies, 10 related to providers untimely endorsing reports, six related to untimely scanning reports, and five related to staff not sending the reports to the providers for endorsement. We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

CHCF needed improvement with diagnostic reports management. Compliance testing revealed providers generally reviewed the pathology reports timely (MIT 2.011, 80.0%) but never communicated pathology results to the patients with complete notification letters (MIT 2.012, zero). OIG clinicians identified 194 deficiencies related to incomplete or missing patient result letters, which accounted for almost all diagnostic health information management deficiencies.[37] We also identified a minor pattern of late provider endorsement of diagnostic results.[38] Please refer to the **Diagnostic Services** indicator for further discussion.

Urgent and Emergent Records

OIG clinicians reviewed 129 emergency care events. CHCF nurses and providers sufficiently recorded these events. Providers usually documented their emergency care encounters, including telephone communication with the nurses when the patients were evaluated in the clinic or TTA after-hours. We did not identify significant deficiencies or problematic patterns. The **Emergency Services** indicator provides additional details.

Scanning Performance

CHCF needed improvement with the scanning process. Compliance testing revealed staff inconsistently labeled, scanned, and filed documents appropriately (MIT 4.004, 66.7%). OIG clinicians identified three deficiencies related to HIM staff delays in scanning documents. However, none of these were significant.

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[36] Specialty health information management deficiencies occurred in cases 2, 3, 5, 11, 14-16, 19, 21, 22, and 26-36. Significant deficiencies occurred in cases 2, 3, 5, 11, 15, 16, 21, 22, 26-28, 31, 33, and 34.

[37] Deficiencies occurred in cases 1-5 and 11-36. None of these deficiencies were significant.

[38] Deficiencies occurred in cases 1, 2, 4, 12, 14, 16-18, 22, 26, 27, 29-34, and 36.

Clinician On-Site Inspection

We discussed health information management (HIM) with the health records technician (HRT) supervisor and HIM staff. They reported vacancies during the OIG period of review, including one health record technician who accepted an out-of-class assignment and one office assistant who transferred to another department. The HRT supervisor reported having an internal tracking system using detailed spreadsheets to ensure documents were received timely from on-site and off-site specialty services and hospitals. The HRT supervisor described a multi-disciplinary system, which included specialty nurses and a protocol to ensure timely receipt of documents. HIM staff stated they scanned most documents they received within one to two business days into the EHRS. Additionally, HIM staff tracked provider report endorsements and contacted providers to review reports when needed.

We discussed the tracking process for providers endorsing laboratory studies. The HRT supervisor reported the institution audited both the provider test endorsement to ensure they were timely as well as the patient result letters to ensure they contained the four required elements per CCHCS policy. The supervisor stated providers have improved when generating "normal" result letters, but sometimes the "abnormal" result letters did not contain all required letter elements.

Compliance Score Results

Table 8. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	29	1	15	96.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	20	0	3	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	16	8	0	66.7%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	20	3	0	87.0%
				Overall percentage (MIT 4): 90.1%

Source: The Office of the Inspector General medical inspection results.

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	6	4	0	60.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	3	7	0	30.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	6	9	0	40.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	10	5	0	66.7%

Source: The Office of the Inspector General medical inspection results.

Recommendations

The OIG offers no recommendations for this indicator.

Health Care Environment

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' performance in maintaining auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score. Our case review clinicians do not rate this indicator.

Because none of the tests in this indicator directly affected clinical patient care (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (55.6%)**

Overall, CHCF's performance with health care environment needed improvement. Medical supply storage areas contained expired, unorganized, unidentified, or inaccurately labeled medical supplies. Several clinics did not meet the requirements for essential core medical equipment and supplies. Staff did not regularly sanitize or wash their hands during patient encounters. In addition, staff did not consistently document verification when performing inventory of emergency medical response bags (EMRB) logs. Lastly, several treatment and urgent carts were missing the minimum required inventory levels of medical supplies. Based on the overall **Health Care Environment** compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Patient Waiting Areas

We inspected indoor and outdoor patient waiting areas. Health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 1). During our inspection, we did not observe overcrowding in any of the clinics' indoor and outdoor waiting areas.

Photo 1. Sufficient Patient Waiting Area (photographed on 2-24-25).

Clinic Environment

All clinic environments were sufficiently conducive for medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 100%).

Of the 38 applicable clinics we observed, 34 clinics contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 89.5%). In three clinics, the examination room chairs had torn covers. In one additional clinic, staff did not properly dispose of or secure a used intravenous (IV) medication with a confidential patient information label.

Clinic Supplies

Only 12 of the 38 applicable clinics followed appropriate medical supply storage and management protocols (MIT 5.107, 31.6%). We found one or more of the following deficiencies in 26 clinics: compromised sterile medical supply packaging; long-term storage of staff's food in the medical supply storage room; expired medical supplies (see Photo 2); unorganized, unidentified, or inaccurately labeled medical supplies; cleaning materials stored with medical supplies; and medical supplies directly stored on the floor.

Only 11 of the 38 applicable clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 29.0%). The remaining 27 clinics lacked medical supplies or contained nonfunctional equipment. The missing items included a nebulization unit, lubricating jelly, an ophthalmoscope, otoscope tips, and tongue depressors. We also found a nonfunctional oto-ophthalmoscope and defibrillator. Additionally, staff did not log the results of the defibrillator performance test within the last 30 days. Several clinic daily glucometer quality control logs were also either inaccurate or incomplete.

Photo 2. Expired clinic medical supply (photographed on 2-24-25).

We examined EMRBs, treatment carts, and urgent carts to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. None of the 18 applicable EMRBs passed our test (MIT 5.111, zero). We found one or more of the following deficiencies in 18 locations: the treatment and urgent carts were missing minimum required inventory levels of medical supplies; medical supplies were found stored beyond manufacturer guidelines; staff had not inventoried the EMRBs when seal tags were replaced; and an EMRB log was missing evidence that staff completed a monthly inventory within the last 30 days.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies appropriately (MIT 5.106, zero). We found medical supplies stored beyond the range of manufacturers' guidelines (see Photo 3) and stored directly on the

Photo 3. Expired medical warehouse supply (photographed on 2-24-25).

floor. In addition, we found the medical supply storage location accumulating dust and not cleaned at the time of our inspection.

While health care leadership reported no major concerns with the medical supply management process, the CEO reported delays in procuring needed supplies. On a positive note, as part of CHCF's continuous improvement effort, the institution created a workgroup to actively address ongoing challenges with the acquisition and delivery of medical supplies to the medical clinics.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected 19 of the 37 applicable clinics (MIT 5.101, 51.4%). In 18 clinics, we found one or more of the following deficiencies: staff did not maintain cleaning logs; insects located in the clinic area (see Photo 4), and a chair in disrepair prohibiting proper disinfection.

Staff in 32 of the 38 clinics properly sterilized or disinfected medical equipment (MIT 5.102, 84.2%). In six clinics, we found one or more of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol; staff did not change the examination table paper in between patient encounters; staff did not stamp the date and initial the packaging of sterilized medical equipment; and staff did not clean and disinfect reusable non-invasive medical equipment after each patient encounter.

We found operating sinks and hand hygiene supplies in the examination rooms in all 38 applicable clinics (MIT 5.103, 100%).

We observed patient encounters in seven applicable clinics. In five clinics, clinicians did not wash their hands before or after examining their patients, or before applying gloves (MIT 5.104, 28.6%).

Photo 4. Insects in the clinic area (photographed on 2-24-25).

Health care staff in 37 of the 38 applicable clinics followed proper protocols to mitigate exposure to bloodborne pathogens and

contaminated waste (MIT 5.105, 97.4%). In one clinic, staff did not verbalize an adequate disinfection process of medical equipment after coming into contact with biohazard waste.

Physical Infrastructure

As part of CHCF's health care facility improvement program (HCFIP) project, on October 14, 2022, the institution started constructing five medication distribution rooms in Facility E. CHCF's health care management believe all clinical areas have physical plant infrastructure to sufficiently provide adequate health care services (MIT 5.999).

Compliance Score Results

Table 10. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	19	18	3	51.4%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	32	6	2	84.2%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	38	0	2	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	5	33	28.6%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	37	1	2	97.4%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	12	26	2	31.6%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	11	27	2	29.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	35	0	5	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	34	4	2	89.5%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	0	18	22	0
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): 55.6%

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs, treatment carts, and urgent carts are regularly inventoried and sealed and should implement remedial measures as appropriate.

Transfers

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health care screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed whether staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated staff performance in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals. Inspectors further confirmed whether staff sent complete medication transfer packages to receiving institutions. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (58.7%)**

Case review found CHCF overall performed satisfactorily in the transfers process. The nurses generally performed good assessments for new patient arrivals, patient hospital returns, and scheduled nurse and provider appointments timely. For patients who transferred out of CHCF, the nurses mostly ensured the required documents were included in the transfer packet to include all essential medications. However, we identified opportunities for improvement in hospital returns. OIG clinicians found nurses often did not contact the hospital to obtain recommendations for patients who returned from a hospitalization. Additionally, we identified opportunities for improvement in medication continuity for patients returning from the hospital, which is further discussed in the **Medication Management** indicator. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed CHCF had a mixed performance in this indicator. The institution performed excellently in completing the assessment and disposition sections of the screening process and performed satisfactorily in medication continuity for newly transferred patients. In contrast, the institution scored very poorly in completing initial health screening forms. Based on the overall **Transfers** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 91 events in 28 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room encounter. We identified 44 deficiencies, seven of which were significant.[39]

Transfers In

OIG clinicians found CHCF's receiving and release (R&R) nurses performed well completing the healthcare screening form and requested nurse and provider appointments within the required timeframe. We reviewed 10 transfer-in events and identified no significant deficiencies.[40]

Compliance testing revealed nurses performed poorly with completing the initial healthcare screening form (MIT 6.001, zero). Specifically, compliance testing showed staff needed significant improvement with completing the initial healthcare screening form timely and documenting an explanation for questions answered "yes" on the screening form. However, compliance testing showed nurses performed excellently with completing the assessment and disposition section of the form (MIT 6.002, 96.0%).

Compliance testing showed CHCF performed sufficiently with maintaining medication continuity for new patient arrivals to the institution (MIT 6.003, 80.0%). However, compliance testing revealed opportunities for improvement with ensuring patient layovers at the institution received their medications without interruption (MIT 7.006, 60.0%). In contrast, OIG clinicians found CHCF performed excellently with ensuring new patient arrivals received their medications without interruption.

Both compliance testing and OIG clinicians found CHCF performed very well with ensuring a provider or nurse evaluated new patient arrivals within the required time frames (MIT 1.002, 92.0%). However, compliance testing revealed staff needed improvement with pending specialty appointments for patients who transferred into the institution. Analysis of the compliance data showed either the specialty service was not scheduled timely, or the patient did not receive the specialty service at all while at CHCF (MIT 14.010, 50.0%).

Transfers Out

OIG clinicians found nurses generally performed well in the transfer-out process. We reviewed six cases and only identified two deficiencies in two cases with missing components in the transfer packet.[41]

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients typically experience severe illness or injury. They require more care and place a strain on the institution's resources. In addition, because

[39] Deficiencies occurred in cases 1-3, 5, 11. 12, 15, 18, 26, 27, 29 and 30. Significant deficiencies occurred in cases 3, 5, 18, 30, and 40.

[40] Transfer-in deficiencies occurred in cases 3 and 39.

[41] Transfer-out deficiencies occurred in cases 40 and 42.

these patients have complex medical issues, successful health information transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

Compliance testing showed CHCF performed sufficiently with ensuring patients had timely follow-up appointments after hospitalizations and emergency room encounters (MIT 1.007, 82.6%). Compliance testing showed providers performed well with reviewing hospital discharge documents within the required time frames (MIT 4.005, 87.0%) and performed excellently in retrieving and scanning hospital records (MIT 4.003, 100%).

OIG clinicians reviewed 54 events in which patients returned from hospitalizations or emergency room encounters.[42] We found nurses generally performed good nursing assessments and interventions for patients returning from a hospitalization. However, we identified a pattern in which nurses frequently did not contact the hospital to request recommendations upon the patient's return. The following is an example.

- In case 30, the patient returned from an emergency room encounter. However, the nurse did not contact the hospital to obtain the discharge recommendations upon the patient's return. The recommendations included starting the patient on an antibiotic. Similar deficiencies occurred in cases 5 and 15.

Compliance testing revealed CHCF performed poorly in medication continuity for patients who returned from an off-site hospitalization (MIT 7.003, 9.5%). The low score was mostly due to medications not being made available by the ordering providers' administration date or time. OIG clinicians found similar results and identified 12 deficiencies related to medication continuity for hospital returns.[43] Please see the **Medication Management** indicator for further discussion.

Clinician On-Site Inspection

While on site, we interviewed the R&R staff. R&R staffing consisted of one registered nurse on each shift. The R&R nurse was knowledgeable about the transfer processes and reported having no issues with pharmacy, supplies, or equipment needed to perform their job. Staff reported six to 12 patients transfer in and out of the facility daily on the day shift. The R&R had licensed correctional clinic (LCC) stock medications available.[44] The R&R nurse notified the utilization management nurse of all patients who arrived at CHCF and of any pending specialty appointments. When patients transfer out of CHCF, the R&R nurse calls or sends a message via Cerner to the receiving facility to communicate pending specialty appointments. According to staff, they had good teamwork with custody staff, administrative staff were supportive, and nursing morale was good.

[42] Hospital return events occurred in cases 1-5, 12, 14, 15, 26-31, and 34.

[43] Hospital return medication deficiencies occurred in cases 1, 5, 12, 15, 18, 27 and 30. Significant deficiencies occurred in cases 5, 18, and 30.

[44] The licensed correctional clinic (LCC) stock medications are provided by the pharmacy for the medical staff to administer that are not patient specific.

Compliance On-Site Inspection and Discussion

No patients transferred out of CHCF during the week of the on-site inspection. Therefore, this test was not applicable for this inspection cycle (MIT 6.101, N/A).

Compliance Score Results

Table 11. Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001)	0	25	0	0
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	24	1	0	96.0%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	16	4	5	80.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 6): 58.7%

Source: The Office of the Inspector General medical inspection results.

Table 12. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	23	2	0	92.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	19	4	0	82.6%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	20	0	3	100%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	20	3	0	87.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	2	19	2	9.5%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	N/A	N/A	N/A	N/A
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	6	4	0	60.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	10	10	0	50.0%

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Nursing leadership should identify the challenges for nursing staff in obtaining hospital recommendations for patients upon return to the institution from hospitalizations and emergency room encounters. Leadership should implement remedial measures as appropriate.

- Nursing leadership should develop strategies to ensure nursing staff completely answer and address required initial health screening questions. Leadership should implement remedial measures as appropriate.

Medication Management

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (70.1%)**

In this cycle, case review found CHCF's overall performance was sufficient in medication management. We found CHCF performed satisfactorily in new medications and performed excellently with ensuring patient transfers received their medications without interruption. We also found patients mostly received their chronic care medications timely. However, we identified opportunities for improvement in medication continuity for hospital returns and determined CHCF needed improvement in medication continuity for specialized medical housing as discussed below. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed CHCF needed improvement in providing medication management services. CHCF performed poorly in providing patients with chronic care medications, newly ordered medications, and community hospital discharge medications. CHCF also showed opportunities for improvement in ensuring medication continuity for patients laying over at CHCF. Based on the overall **Medication Management** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 192 events in 37 cases related to medications and found 47 medication deficiencies, 18 of which were significant.[45]

New Medication Prescriptions

OIG clinicians found CHCF performed satisfactorily for new prescription medications. We found patients mostly received their newly ordered medications timely. We identified five deficiencies, one of which was significant.[46] In contrast, compliance testing showed staff needed improvement in administering new medications within the required time frame (MIT 7.002 52.0%). Analysis of the compliance data showed 12 of the 25 patients did

[45] Deficiencies occurred in cases 1, 2, 5, 12, 14, 15, 17, 18, 22, 23, 25-30, 34, 35 and 40. Significant deficiencies occurred in cases 1, 2, 5, 17, 18, 26, 27, 28, 29, 30 and 40.

[46] New medication deficiencies occurred in cases 14, 25, 29, 35. A significant deficiency occurred in case 29.

not receive their medications within the required time frames. The low score was mostly due to new medications not being available or not being administered timely.

Chronic Medication Continuity

Compliance testing showed patients intermittently received their chronic care medications within the required time frame (MIT 7.001, 63.6%). The lower scoring was mostly due to medications not being made available to the patient by the ordering provider's administration date. OIG clinicians found CHCF performed satisfactorily in chronic care medications. Patients mostly received their chronic care medications without interruption. We identified seven deficiencies, three of which were significant.[47] The following is an example:

- In case 2, we identified a lapse in medication continuity for regular insulin sliding due to a lapse in renewing the medication timely. In addition, the provider incorrectly ordered the insulin sliding scale method of administration as oral instead of subcutaneous. In the same case, the patient did not receive their daily dose of chronic care medication, patiromer, prescribed to treat elevated potassium levels. Documentation in the medication administration record (MAR) stated "Not Done: Med not available."

Hospital Discharge Medications

Compliance testing revealed CHCF performed poorly with medication continuity for patients who returned from hospitalizations or emergency room encounters (MIT 7.003, 9.5%). Analysis of the compliance data showed the low score was mostly due to patients not receiving their medications by the ordering provider's administration date or time.

OIG clinicians identified opportunities for improvement in medication continuity for hospital returns. We identified 12 medication deficiencies, four of which were significant.[48] We also identified a pattern of patients returning from the hospital who did not receive their prescribed medications, such as chronic care eye drop medications, within the required time frame. The following are examples:

- In case 18, the provider ordered post-hospitalization medications to treat glaucoma, dorzolamide-timolol and brimonidine. However, the patient received the brimonidine eye drops one day late, due to "medication not available." In addition, the patient received the medication dorzolamide-timolol 10 days later. Similar deficiencies occurred in cases 15, 27, and 30.

- In case 30, the patient returned from the hospital with a recommendation to start the antibiotic, cephalexin. However, CHCF medical staff did not order this medication.

[47] Chronic care medication deficiencies occurred in cases 2, 17, 22, 23, and 26. Significant deficiencies occurred in cases 2, 17, and 26.

[48] Hospital return medication deficiencies occurred in cases 1, 5, 12, 15, 18, 27, and 30. Significant deficiencies occurred in cases 5, 18, and 30.

Specialized Medical Housing Medications

Compliance testing revealed CHCF performed poorly in medication continuity for new patient admissions (MIT 13.003, 20.0%). Analysis of the compliance data showed, in 16 of 20 case samples, most patients received their medications up to one day late. These medications included those to treat blood pressure, diabetes, enlarged prostate, high cholesterol, and blood clots.

OIG clinicians similarly found CHCF performed poorly in medication management for specialized medical housing. Out of the 192 medication events, 102 events occurred in specialized medical housing. We identified 19 deficiencies in nine cases, five of which were significant.[49] We also identified several lapses in medication continuity and a pattern in which patients were prescribed rescue medications as nurse administered instead of keep-on-person (KOP) without documentation to substantiate this deviation.[50] The following are examples:

- In case 1, during the month of July, the provider placed an order to administer medications prescribed three times per day prior to the patient going to dialysis and medications twice per day after the patient returned on dialysis days. However, the patient frequently did not receive their scheduled chronic care medications on dialysis days as ordered.

- In case 5, during the month of July, the provider ordered rescue medication nitroglycerin as direct observation therapy. However, the medication should have been ordered as KOP per policy. Similar deficiencies occurred in cases 12 and 30.

- In case 18, the order for chronic care blood pressure medication, metoprolol, was completed. However, medical staff did not renew this medication. The patient did not receive this prescription until the following month, resulting in a lapse in medication continuity.

- In case 30, the patient's chronic care high cholesterol medication, atorvastatin, expired. However, medical staff did not renew the medication order, and the patient was without this chronic care medication for the remainder of the review period.

Transfer Medications

OIG clinicians found CHCF performed excellently with ensuring patients who transferred into the facility received their medications without interruption. Patients who transferred out of the facility mostly received their required five-day supply of medications.

Compliance testing showed CHCF performed sufficiently with maintaining medication continuity for new patient arrivals to the institution (MIT 6.003, 80.0%). In contrast,

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[49] Specialized Medical Housing medication deficiencies occurred in cases 1, 5, 12, 15, 18, 27, 28, 30, and 34. Significant deficiencies occurred in cases 1, 18, 27, 28, and 30.

[50] Nurse-administered medication is medication the nurse administers to the patient at the scheduled prescribed times. KOP means "keep-on-person" and refers to medications a patient can keep and self-administer according to the directions provided.

compliance testing revealed opportunities for improvement with ensuring patient layovers at the institution received their medications without interruption (MIT, 7.006, 60.0%). Compliance testing showed, in four of the 10 case samples, patients did not receive their medications without interruption.

Medication Administration

Compliance testing showed CHCF performed perfectly in administering tuberculosis (TB) medications (MIT 9.001, 100%). In addition, the nurses monitored all patients who were prescribed TB medications as required (MIT 9.002, 100%). OIG clinicians similarly did not identify any concerns related to TB medications.

Clinician On-Site Inspection

OIG clinicians interviewed pharmacy and nursing staff. The staff stated the pharmacy was open seven days per week, with shortened hours on the weekends. Staff also noted, at the time of the on-site inspection, the pharmacy was experiencing a staffing shortage.

OIG clinicians interviewed the medication nurses in the E clinic, C unit, and D unit. Staff in each area reported patient medications were generally available, but at times, staff may need to obtain stock medications from other units. The LVN staff attended morning huddles and were knowledgeable about processes including KOP medications, medication noncompliance, and the transfer process. The E clinic served patients in the outpatient setting and had seven LVNs assigned for day shift and evening shift. Six LVNs administered medications and the seventh LVN was assigned as the medical first responder and treatment nurse. The treatment nurse also performed wound care, administered vaccines, provided patient education, and saw an average of 10 to 12 patients daily.

The C and D units contained the specialized medical housing units. In these units, the LVN staff administered medications, performed wound care, assisted with patient rounds, and answered call lights. In addition, the LVNs had assigned roles for emergency response in their units. The nurses reported nursing morale was fair, and custody staff and administrative staff were supportive.

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in all 36 applicable clinic and medication line locations (MIT 7.101, 100%).

CHCF appropriately stored and secured nonnarcotic medications in 31 of 40 applicable clinic and medication line locations (MIT 7.102, 77.5%). In nine locations, we observed one or more of the following deficiencies: we found accumulated dust, dirt, and old neglected spills in the medication storage areas; the daily seal security check log was not complete for the most recent 30 days; medications were not securely stored as required by CCHCS policy; and the treatment cart log was missing security check entries and was not secure with a red tamper-resistant number seal.

Staff kept medications protected from physical, chemical, and temperature contamination in 25 of 40 applicable clinic and medication line locations (MIT 7.103, 62.5%). In 15 locations, we found one or more of the following deficiencies: the

temperature log had out-of-range temperature readings; staff did not store external and internal medications separately; and the medication refrigerator was unsanitary.

Staff successfully stored valid, unexpired medications in 29 of 39 applicable medication line locations (MIT 7.104, 74.4%). In 10 locations, we found one or more of the following deficiencies: medication nurses did not label the multi-use medication as required by CCHCS policy; previously opened multi-dose medication was found stored beyond use date; and staff did not store intravenous (IV) solutions according to manufacturers' guidelines.

Nurses exercised proper hand hygiene and contamination control protocols in three of seven applicable locations (MIT 7.105, 42.9%). In four locations, some nurses neglected to wash or sanitize their hands before donning gloves or before each subsequent regloving.

Staff in all seven applicable medication preparation and administration areas demonstrated appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 100%).

Staff in two of seven applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 28.6%). In five locations, we observed one or more of the following deficiencies: medication nurses did not always verify patient's identification using a secondary identifier; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; and medication nurses did not disinfect the insulin port before drawing medication for injection administration.

Pharmacy Protocols

Pharmacy staff followed general security, organization, and cleanliness management protocols for nonrefrigerated and refrigerated medications stored in its pharmacies (MIT 7.108, 7.109, and 7.110, 100%).

Pharmacy staff did not appropriately complete monthly inventories of controlled substances in the institution's main pharmacy. Specifically, the pharmacist present at the time of the pharmacy inspection did not complete filling out several areas in the medication storage area inspection checklist (CDCR Form 7477) (MIT 7.111, 50.0%).

We examined 25 medication error reports. The pharmacist in charge (PIC) timely and correctly processed all reports (MIT 7.112, 100%).

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At CHCF, the OIG did not find any applicable medication errors (MIT 7.998).

At the time of our inspection, CHCF's restricted housing unit was closed; therefore, this test was not applicable (MIT 7.999).

Compliance Score Results

Table 13. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	14	8	3	63.6%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	13	12	0	52.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	2	19	2	9.5%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	N/A	N/A	N/A	N/A
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	6	4	0	60.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	36	0	5	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	31	9	1	77.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	25	15	1	62.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	29	10	2	74.4%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	4	34	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	7	0	34	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	2	5	34	28.6%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	1	0	50.0%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	25	0	0	100%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): 70.1%

Source: The Office of the Inspector General medical inspection results.

Table 14. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	16	4	5	80.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	N/A	N/A	N/A	N/A
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	3	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	3	0	0	100%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	16	2	20.0%

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical and nursing leadership should determine the challenges to ensuring chronic care patients, hospital discharge patients, and patients admitted to specialized medical housing receive their medications timely and without interruption. Leadership should implement remedial measures as appropriate.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as being at high risk for coccidioidomycosis (Valley Fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Proficient*** **(98.2%)**

CHCF performed exceptionally in preventive services. Staff always administered TB medications to patients as prescribed, monitored patients taking TB medications, screened patients annually for TB, and offered colorectal cancer screening for patients ages 45 through 75. Staff also almost always offered patients an influenza vaccine for the most recent influenza season and required immunizations for chronic care patients. These findings are set forth in the table on the next page. Based on the overall **Preventive Services** compliance score result, the OIG rated this indicator ***proficient***.

Compliance Score Results

Table 15. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	3	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	3	0	0	100%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	24	1	0	96.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	25	0	0	100%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	14	1	10	93.3%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): 98.2%

Source: The Office of the Inspector General medical inspection results.

Recommendations

The OIG offers no recommendations for this indicator.

Nursing Performance

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RN), licensed vocational nurses (LVN), psychiatric technicians (PT), certified nursing assistants (CNA), and medical assistants (MA). We evaluated nurses' performance in making timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance across many clinical settings and processes, including sick call, outpatient care, care coordination and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing nursing performance, OIG clinicians understand that nurses perform numerous aspects of medical care. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing.**

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Not Applicable***

Case review found CHCF's overall nursing performance needed improvement. Unlike other institutions, most CHCF patients reside in specialized medical housing units. While nursing performance was satisfactory with some opportunities for improvement in the areas of transfers, medication management, emergency services, and outpatient care, we found nurses primarily needed improvement in specialized medical housing. In specialized medical housing, we identified multiple patterns of incomplete assessments, including admission assessments and wound care, as well as a lack of timely notifications to providers and nurses when a patient's condition changed. We also found multiple delays in contacting emergency medical services for emergency events. In addition, we identified a pattern in which medical leadership did not perform clinical reviews for emergency events and did not always identify the training opportunities we found. Considering all factors, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 513 nursing encounters in 60 cases. Of the nursing encounters we reviewed, 80 occurred in the outpatient setting, and 41 were sick call requests. We identified 214 nursing performance deficiencies, 41 of which were significant.[51]

[51] Deficiencies occurred in cases 1-15, 22-31, 39, 40, 42, 43, 45-49, 51-55, 57, and 62-66. Significant deficiencies occurred in cases 1-15, 22-31, 39, 40, 42, 43, 45-49, 51-55, 57, 62, 63, and 66.

Outpatient Nursing Assessment and Interventions

OIG clinicians found CHCF nursing performance was satisfactory in the outpatient clinics. We reviewed 80 outpatient nursing events and identified 52 nursing deficiencies, 12 of which were significant.[52] We found the nurses generally performed appropriate assessments and interventions. However, we identified a pattern of deficiencies related to incomplete assessments, provider follow-up appointments, and providing patient education. The following are examples:

- In case 2, the nurse assessed the patient for a follow-up appointment regarding a low blood sugar episode. However, the nurse did not provide patient education. Similar deficiencies occurred in cases 23, 24, 25, 47, 48, and 51.

- In case 24, the sick call nurse assessed the patient for complaints of difficulty breathing at night. The patient requested an oxygen concentrator for nighttime use. The nurse documented a message would be sent to the provider to inquire whether the patient was eligible. However, the nurse did not initiate a follow-up appointment with the provider to further address the need for an oxygen concentrator. In addition, the medical record contained no evidence the nurse communicated this request to the provider. Further, the nurse did not assess how frequently the patient was using his rescue inhaler, levalbuterol.

- In case 64, a sick call nurse assessed the patient for complaints of his hearing, memory, eyesight, and wheezing worsening for the past four years. However, the nurse did not perform a visual acuity examination or inquire how often the patient was using his rescue inhaler. In addition, the nurse documented the need for a provider follow-up within 14 calendar days in the progress note. However, the nurse did not initiate an order for the provider follow-up appointment, resulting in the provider not evaluating the patient for the specific complaints.

Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Although outpatient clinic nurses generally performed good documentation, we identified a pattern of missing documentation. The following is an example:

- In case 2, the sick call nurse assessed the patient for complaints of worsening chronic right foot neuropathy.[53] However, the nurse did not document the patient's right extremity sensation or response to touch.

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[52] Outpatient nursing deficiencies occurred in cases 2, 14, 23-26, 29, 30, 43, 45-49, 51, and 52. Significant deficiencies occurred in cases 2, 29, 30, and 53

[53] Neuropathy is nerve damage to the body commonly in the hands and feet that can cause symptoms such as pain, numbness, tingling, or weakness.

Wound Care

Our clinicians found CHCF nursing staff needed improvement in wound care. We reviewed 12 cases involving wound care orders and identified 22 deficiencies, nine of which were significant.[54] We identified a pattern on several days where nurses frequently did not perform complete wound care assessments. At times, the nurses did not document the site on which they performed the wound care, or the details of the wound care provided. The following are examples:

- In case 3, during the period from August to December 2024, the patient had multiple daily wound care orders for different areas. The nurses completed portions of the wound care forms. However, the nurses rarely assessed the wound care sites, document the wound care performed, or specify on which wound site the dressing change was applied.

- In case 29, during the month of October 2024, the patient had a left thigh wound with Penrose drains and a right fifth toe amputation wound.[55] The nurses rarely documented a description of the wound bed, surrounding skin tissue, presence of Penrose drains, or the wound care performed and dressing applied. In addition, the nurses often did not perform wound care on the right fifth toe amputation as ordered.

Emergency Services

OIG clinicians reviewed 70 urgent/emergent events and found 93 emergency care deficiencies. Of these 93 deficiencies, 38 related to nursing performance, 10 of which were significant. We found nursing performance had opportunities for improvement in emergency care with incomplete assessments, interventions, and documentation. Please refer to the **Emergency Services** indicator for further detail.

Hospital Returns

OIG clinicians reviewed 54 events involving returns from off-site hospitals or emergency rooms. We found the nurses generally performed good nursing assessments and interventions. However, we identified a pattern in which nurses frequently did not contact the hospital to request recommendations upon the patient's return, which we detailed further in the **Transfers** indicator.

Transfers

OIG clinicians reviewed eight cases involving transfer-in and transfer-out processes. The nurses overall performed good assessments, completed the healthcare screening, and initiated provider appointments within the required time frames. Please refer to the **Transfers** indicator for further details.

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[54] Wound care deficiencies occurred in cases 3, 5, 15, 29, and 30. Significant deficiencies occurred in cases 3, 29, and 30.

[55] A Penrose drain is a tube used after surgery to drain extra fluid like blood or pus out of the body, preventing infection and swelling.

Specialized Medical Housing

OIG clinicians reviewed 261 nursing events in the specialized medical housing (SMH). We identified 93 deficiencies related to nursing performance, 16 of which were significant. We found nursing performance needed improvement.[56] Specifically, we found patterns of deficiencies related to nursing assessments and interventions, such as not performing thorough wound and PICC line assessments, not assessing blood pressure or heart rate prior to administering medications, and failing to notify the RN or provider for changes in patient conditions. Please refer to the **Specialized Medical Housing** Indicator for additional details.

Specialty Services

OIG clinicians reviewed 40 events in which nurses assessed patients after an off-site specialist procedure and consultation. Our clinicians found opportunities for improvement in this area. We identified 13 deficiencies, two of which were significant.[57] We also identified a pattern in six cases in which nurses often did not contact the specialty provider to obtain immediate recommendations.[58] Please refer to the **Specialty Services** indicator for additional details.

Medication Management

OIG clinicians reviewed 192 events involving medication management and found most nurses administered patients' medications as prescribed. However, we found CHCF showed opportunities for improvement in medication continuity for patients who returned from the hospital and were housed in specialized medical housing. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

We interviewed various nursing staff throughout the institution, including RNs, LVNs, supervising registered nurses (SRNs), and nursing leadership. Nursing staff were knowledgeable regarding processes in their assigned areas. We found huddles were well organized with good staff participation and nurses were familiar with their patients.

The E clinic staff informed us they do not have a backlog for nursing appointments. The E clinic had four care teams, with a provider and nurse assigned to each team. The sick call nurses assess 11 to 13 patients daily. They have two care manager RNs for the outpatient setting, who assess an average of 14 patients daily. The care manager duties included: monitoring registries for chronic diseases, scheduling patient appointments, reviewing patient medications and vital signs, providing patient education for noncompliance with laboratory tests, and on-site and off-site specialty appointments. In addition, the care manager is also a medical responder for the E yard.

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[56] SMH nursing performance deficiencies occurred in cases 1, 4-15, and 27-31. Significant deficiencies occurred in cases 1, 4—6, 12, 13, and 15.

[57] Specialty Service nursing deficiencies occurred in cases 2, 12, 15, 22, 23, 26, and 29. Significant deficiencies occurred in cases 23 and 29.

[58] Nurses did not contact the specialty provider to obtain immediate recommendations in cases 2, 12, 15, 22, 26, and 29.

CHCF's wound care team consists of two RNs and two LVNs. One RN is assigned to buildings D1-3 and the other to C4-6. The remainder of the patients from the B, C, and E yards come to the procedure clinic for wound care. The wound care nurses assess patient wounds weekly, which includes wound pictures and measurements. The LVNs assist with wound dressings and order all supplies needed for wound care. The LVNs are also a part of the audit team for tracking wound documentation. CHCF has a referral process to notify the wound team when patients are identified to have wounds. In addition, the CHCF wound care nurses meet weekly with the CCHCS wound care team to review patient wound care and progress as well as to obtain recommendations. Once the CCHCS provider makes recommendations, the institution's provider will enter wound care orders in the electronic health record.

At the time of our clinician on-site inspection, the chief nurse executive (CNE) at CHCF had been in an acting role for one month and CHCF had two assistant CNEs. Nursing leadership reported nursing quality improvement projects included workgroups for hunger strikes, discrepancies in controlled substances, patient falls, and wound care. Nursing leadership reported nursing morale and relationship with custody was fair.

Nursing leadership informed us buildings D4, D5, and D6 had been deactivated of CTC level of care and would house assisted living OHU-type of patients. In addition, building C1 will house geriatric patients. Patients must meet specific criteria to be housed in these areas.

Recommendations

- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from performing complete assessments, initiating provider follow-up appointments when warranted, and providing appropriate patient education. Leadership should implement remedial measures as appropriate, including training staff as needed.

- Nursing leadership should develop and implement strategies to ensure CTC nurses complete documentation of wound care assessments including clinical appearance of the wound, surrounding tissue, and measurements.

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. We assessed the institution's providers' performance in evaluating, diagnosing, and managing their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. We assessed provider care through case review only and performed no compliance testing for this indicator.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Not Applicable***

Case review found CHCF providers generally delivered satisfactory medical care. Compared to Cycle 6, provider performance significantly improved as providers appropriately addressed their patients' medical conditions, formulated accurate differential diagnoses for their patients' symptoms, and followed through with appropriate treatment plans. Providers delivered good care in the CTC, OHU, and outpatient and emergency settings. However, we identified a pattern of providers insufficiently managing patients on chronic anticoagulation. Additionally, providers inconsistently documented vital signs or pertinent physical examination findings. After considering all aspects of care, the OIG rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed 320 medical provider encounters and identified 128 deficiencies related to provider performance, 30 of which were significant.[59] In addition, OIG clinicians examined the quality of care in 31 comprehensive case reviews. Of these 31 cases, we rated 26 ***adequate*** and five ***inadequate***.[60] We also performed focused reviews on three cases, all of which we rated ***adequate***.

Assessment and Decision-Making

Providers usually obtained accurate histories and documented appropriate assessments for their patients. They often formulated good differential diagnoses and referred their patients to specialists when medically indicated. Additionally, providers generally ordered necessary laboratory tests and imaging studies to further evaluate and manage their patients' various symptoms and concerns. OIG clinicians identified 34 deficiencies

[59] Deficiencies occurred in cases 1-5, 11, 12, 14-20, 22-24, 26-36, and 39. Significant deficiencies occurred in cases 1, 3, 5, 12, 14, 15, 17, 18, 20, 27, 29, 30, 32, 33, and 34.

[60] OIG clinicians rated cases 5, 17, 18, 29, and 34 ***inadequate***.

related to poor assessments and decision-making, 15 of which were significant.[61] The following are examples:

- In case 3, the provider evaluated the patient and documented the patient had anemia of chronic disease.[62] However, the patient had an active prescription for iron supplementation tablets and no recent iron studies to confirm whether this medication was medically indicated.

- In case 5, the provider evaluated the patient, who was recently hospitalized for pneumonia and on antibiotics, but did not address abnormal laboratory results of an elevated kidney laboratory test and elevated white blood cell count. These abnormalities suggested the patient may have been dehydrated with a worsening infection despite receiving antibiotic therapy.

- In case 27, the provider evaluated the patient to follow up on a recent hospitalization during which the patient received chemotherapy for lymphoma, a type of cancer. However, the provider did not address the hospital's recommendation to order the medication, Neulasta.[63] This omission increased the risk for severe infection, as this patient had a low white blood cell count.

- In case 32, the provider evaluated the patient for a breast lump and ordered an ultrasound-guided biopsy to occur with medium-priority time frame within 45 days. However, the provider should have ordered this procedure urgently since the breast lesion could possibly have been cancerous.

Emergency Care

In the SEMS unit, providers usually performed well in managing patients with urgent and emergent conditions and were available for emergency consultations. OIG clinicians identified 13 deficiencies related to emergency care, two of which were significant. We discuss these further in the **Emergency Services** indicator.

Specialized Medical Housing

Providers performed excellently in managing patients housed within the CTC and OHU. OIG clinicians did not identify any problematic patterns with provider performance for patients in specialized medical housing. We also discuss specialized medical housing provider performance in the **Specialized Medical Housing** indicator.

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[61] Deficiencies in assessments and decision making occurred in cases 1, 3, 5, 12, 14, 17, 18, 20, and 26-34. Significant deficiencies occurred in cases 1, 3, 5, 12, 14, 17, 18, 20, 27, 30, 32, and 33.

[62] Anemia of chronic disease is a low red blood cell count due to a prolonged illness of various causes, such as kidney disease, autoinflammatory disorder, or cancer. The low red cell count is improved by treating these underlying conditions.

[63] Neulasta, or pegfilgrastim, is a medication administered to patients to increase the neutrophil count. Neutrophils are a type of white blood cell in the body which fight infections. Administering Neulasta reduces the risk of a patient developing a severe infection when their white blood cell counts are affected by medical disorders, cancer, and chemotherapy.

Specialty Services

Providers appropriately referred their patients to specialty services for advanced diagnostics imaging, procedures, and specialty consultations when medically indicated. They usually addressed the specialists' recommendations and ordered follow-up appointments appropriately. We discuss provider performance further in the **Specialty Services** indicator.

Review of Records

Provider review of medical records is essential to understand the patient's past medical history and to plan treatment. Providers generally performed good reviews of records. OIG clinicians identified five minor deficiencies related to insufficient review of medical records.

Patient Notification Letter

Providers frequently sent incomplete patient notification letters. OIG clinicians identified numerous examples of the letters not including all four required components per CCHCS policy. The deficiencies occurred in all 31 detailed cases we reviewed.[64] We discuss this further in the **Diagnostic Services** and **Health and Information Management** indicators.

Chronic Care

Providers addressed most of their patients' chronic health conditions well. They appropriately managed their patients with asthma, cardiovascular disease, chronic kidney disease, hepatitis C, diabetes, and hypertension. However, OIG clinicians identified a pattern of providers needing improvement in managing their patients on anticoagulation with warfarin.[65] The following are examples:

- In case 17, the patient received warfarin chronically for management of antiphospholipid syndrome (APS). [66] However, the patient did not receive an INR test for more than one month. Patients on warfarin require routine INR checks to ensure their blood is appropriately thinned and to determine whether warfarin adjustments are required.[67]

- In case 18, the provider reviewed an abnormal laboratory result with an elevated INR of 10.9.[68] However, the provider did not order to withhold or

[64] Incomplete or missing patient notification letters occurred in cases 1-5 and 11-36.

[65] Warfarin is a blood thinning medication.

[66] Antiphospholipid syndrome (APS) is an autoimmune disorder in which the body produces antibodies promoting clot production. Patients with APS are at increased risk for blood clots and strokes and require chronic anticoagulation. Warfarin reduces the risk of blood clots and strokes.

[67] A patient's use of warfarin requires laboratory testing to monitor its effectiveness. Patients on warfarin require weekly to monthly INR laboratory tests. If the INR levels fluctuate beyond therapeutic levels, more frequent testing is required.

[68] INR, International Normalized Ratio, is a laboratory test to measure the body's blood clotting. This test is used to monitor the effectiveness of blood thinning medications such as warfarin. The usual range is from 2 to 3.

discontinue the patient's warfarin dose. This action increased the patient's risk for a life-threatening bleed.[69]

Documentation Quality

Documentation provides essential information for the patient's health and care plan. Providers should document vital signs and pertinent physical examination findings, as these details specify the patient's current condition and whether treatment changes are indicated. OIG clinicians identified a pattern of providers not consistently documenting vital signs or physical examinations when they were clinically indicated.[70] The following are examples:

- In case 11, the provider evaluated the patient at a follow-up appointment and referred the patient to the wound specialist. However, the provider did not document a skin examination.
- In case 14, the provider evaluated the patient with end-stage liver disease but did not document vital signs or a physical examination.
- In case 16, the provider evaluated the patient for follow-up of pneumonia but did not document a pulmonary examination.
- In case 29, the provider evaluated the patient, who was recently hospitalized for a severe skin infection. However, the provider did not document vital signs or a physical examination.

Provider Continuity

CHCF ensured excellent provider continuity for their patients. OIG clinicians found CHCF clinic providers cross-covered their partners' patients when they were on leave.

Clinician On-Site Inspection

The OIG physicians met with the two chief medical executives (CMEs) and three chief physician and surgeons (CP&Ss). Medical leadership stated CHCF had no provider vacancies during the period of review or at the time of the on-site inspection. Due to the complexity of patients housed at CHCF as well as CHCF's multi-faceted medical missions, CCHCS headquarters allotted 32 provider positions. CHCF employed one registry physician, who worked in the SEMS unit. Management reported no difficulty in either hiring or retaining providers. They attributed full staffing to the institution's location, collegial atmosphere, and 15 percent pay differential. They mentioned CHCF received the most medically complicated patients throughout the state, including the majority of dialysis patients. At the time of the inspection, they reported 109 dialysis patients. Leadership stated approximately 20 patients are hospitalized at any given time and up to 250 patients transferred to higher levels of care each month. Additionally, CHCF housed patients within specialized geriatric care, memory care, and assisted living

[69] Significantly elevated INR values (usually greater than 4.0) require the provider to either hold or discontinue warfarin.

[70] Deficiencies occurred in cases 2-5, 11, 12, 14-16, 19, 23, and 27-36.

units. Leadership also reported they serve as conservators for patients who lack the capacity to make decisions for their care.

The OIG clinicians interviewed the providers to better understand their ability to administer care and discuss the case deficiencies. As discussed in the Access to Care indicator, during the morning huddles, the providers displayed an in-depth understanding of their patients. The providers reported following their patients for several years at a time and knowing their patients well.

Many providers reported good morale. Despite taking care of the state's most medically and psychiatrically complex patients, they reported enough staffing and sufficient support from leadership. Furthermore, they enjoyed taking care of their patients. They stated on-call duties could become onerous due to the sheer volume of calls received. However, this was mitigated by evening and weekend provider coverage. The providers bid for their positions in a particular clinic based on seniority. They reported a recent increase in workload within the outpatient clinic due to an influx of medically complex patients from other institutions. Despite the challenges of working with patients requiring close evaluations and at high risk for clinical decompensation, the majority of providers were happy with their job and felt fulfilled.

Recommendations

- Medical leadership should identify the root cause(s) for the poor management of patients on warfarin and implement remedial measures as appropriate.
- Medical leadership identify the root cause(s) for providers not documenting pertinent vital signs and pertinent physical examinations and implement remedial measures as appropriate.

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. At the time of our inspection, CHCF's specialized medical housing consisted of correctional treatment centers (CTC) and outpatient housing units (OHU).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Inadequate* (74.3%)**

Case review found CHCF needed improvement in delivering care for specialized medical housing patients. The SMH providers generally provided good care and made accurate assessments and decisions; however, we reached findings in nursing performance similar to Cycle 6, indicating nurses needed improvement. Specifically, we identified patterns of deficiencies related to nursing assessments, interventions, and medication administration. Examples included missing components of the nursing assessment, delays in calling 911, and lapses in medication administration. The OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed CHCF had a mixed performance in specialized medical housing care. Nursing staff performed excellently in timely completing admission assessments, and providers performed satisfactorily in timely completing history and physical examinations. In contrast, nursing staff needed improvement in ensuring medication continuity for newly admitted patients in the specialized medical housing units. Based on the overall **Specialized Medical Housing** compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 692 specialized medical housing events in the OHU and CTC, which included 204 provider events and 261 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified 172 deficiencies, 36 of which were significant.[71]

[71] Deficiencies occurred in cases 1-5, 11, 12, 15, 16, 18- 20, 27, 28, 30, 31, and 34. Significant deficiencies occurred in cases 1, 3-5, 11, 12, 18, 20, 27, 28, 30, and 34.

Provider Performance

Providers generally delivered good care within the CTC and OHU. Compliance testing showed providers usually completed all admission history and physicals without delay (MIT 13.002, 81.8%). OIG clinicians found the providers made accurate assessments and decisions for their patients. Additionally, providers ensured adequate follow up for patients returning from a higher level of care and specialty consultations. We discuss these findings further in the **Provider Performance** indicator.

Nursing Performance

OIG clinicians found nursing performance in the SMH needed improvement. The clinicians reviewed 261 nursing events and identified 93 deficiencies, 16 of which were significant. SMH nurses performed daily and admission assessments timely. However, we found patterns of deficiencies related to nursing assessments and interventions. For emergency care, SMH had delays in calling 911 as discussed in the **Emergency Services** indicator. When patients had specific complaints, the nurses did not always perform thorough assessments, including wound and peripherally inserted central catheter (PICC) line assessments.[72] In addition, the nurses did not assess the patient's blood pressure or heart rate prior to administering heart medications. Further, the nurses did not notify the provider for changes in patients' conditions, and the LVNs and certified nursing assistants (CNAs) did not always notify the RN for abnormal vital signs. The following are examples:

- In case 1, the OHU nurse completed the initial assessment for the patient, who transferred to the OHU from the CTC. The nurse documented the patient had low blood pressure and a low heart rate; however, the nurse did not assess the patient for cardiac symptoms, notify the provider, or perform a blood pressure re-check. Further, the nurse did not assess lung sounds, heart rhythm, bowel sounds, extremity strengths, or range of motion. Additionally, the nurse documented completing a skin assessment with no findings; however, the nurse did not assess the dialysis catheter site to the right upper chest and dressing.

- In case 3, the RN completed the admission assessment for the patient, who was admitted to the CTC after discharging from the hospital. The patient had a PICC line on the right arm for antibiotic therapy; however, the nurse did not obtain the catheter measurements to include arm circumference and PICC line patency. In addition, the nurse did not obtain an initial admission weight.

- In a separate event in case 3, the nurse changed the patient's suprapubic catheter after the patient complained of feeling pressure in his bladder and reported his catheter was clogged.[73] The nurse did not perform a pain assessment, palpate the abdomen, or assess for tenderness or bladder distention. Additionally, the nurse did not notify the provider of the patient's

[72] A peripherally inserted central catheter (PICC) provides intravenous access to administer fluids and medication.

[73] A suprapubic catheter is a tube inserted in the lower abdomen into the bladder to drain urine.

change in condition or document the amount of urine output or a description after inserting the suprapubic catheter.

- In case 11, during the review period from April through September 2024, the nurses did not consistently check the patient's blood pressure prior to administering cardiac medication. Additionally, during the review period months of April through July, and September 2024, the patient's blood pressure was frequently elevated. However, the CNAs did not always perform a blood pressure re-check or report the abnormal results to the RN.

- In case 12, the patient, who was negative for stroke symptoms, complained of dizziness and his heart beating fast. The OHU nurse did not assess the patient for chest pain and inappropriately administered sublingual Nitroglycerin to the patient, despite the patient's low blood pressure.

The SMH areas maintained an operational call system (MIT 13.101, 100%). Both case review and compliance testing concluded SMH nurses frequently completed initial health assessments timely (MIT 13.001, 95.5%).

Medication Administration

Overall, the SMH had poor performance for medication administration. Compliance testing revealed the institution performed poorly with timely administering medications upon admission to SMH (MIT 13.003, 20.0%). OIG clinicians identified 19 deficiencies related to medication management, five of which were significant.[74] We identified delays related to chronic care and newly ordered medications. We also identified instances where providers ordered medications as nurse administered instead of keep-on-person without documenting the medical rationale.[75] In addition, the nurses did not always assess the patients' blood pressure or heart rate prior to administering heart medications. The following are examples:

- In case 1, from July 2024 to December 2024, the patient was prescribed multiple blood pressure medications with specific blood pressure parameter instructions. However, the OHU nurses frequently did not perform a blood pressure check as ordered prior to administering blood pressure medications.

- In case 28, from July 2024 to December 2024, the nurses did not consistently check the patient's blood pressure and heart rate prior to administering the patient's heart medication as ordered.

Please refer to the **Medication Management** indicator for further details.

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[74] Medication management deficiencies occurred in cases 1, 5, 12, 15, 18, 27, 28, 30, and 34. Significant deficiencies occurred in cases 1, 18, 27, 28, and 30.

[75] Nurse-administered medication is medication the nurse administers to the patient at the scheduled prescribed times. KOP means "keep-on-person" and refers to medications a patient can keep and self-administer according to the directions provided. The medications included sublingual nitroglycerin in cases 5 and 12, and levalbuterol inhaler in case 30.

Clinician On-Site Inspection

Our clinicians inspected the OHU and the CTC, interviewed the nursing staff, and attended well-organized huddles. Required staff were present for the huddles, including the medication nurses. During the huddles, the provider and unit staff communicated patient concerns and engaged in good discussions regarding patient care. Each unit had an assigned provider. The CTC units had an RN shift lead role. Some of the duties of the shift lead were to serve as a roving nurse to assist the other nursing staff as well as to ensure all nursing tasks were completed and supplies were ordered. Unlike other institutions, CHCF staffed the OHU with RNs on each shift.

Both OHU and CTC staff reported they had no issues with pharmacy. Medications were available and delivered as required. The staff reported they had necessary equipment to provide nursing care, and maintenance staff completed equipment repairs timely. Staff informed us they did have issues with receiving items timely from the warehouse, with one example being wound care supplies.

The staff informed us nursing morale was fair, administration was supportive, and they had a good relationship with custody.

Compliance Score Results

Table 16. Specialized Medical Housing

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	21	1	0	95.5%
Was a written history and physical examination completed within the required time frame? (13.002)	18	4	0	81.8%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	16	2	20.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	28	0	1	100%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	29	N/A
				Overall percentage (MIT 13): 74.3%

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Nursing leadership should determine the challenges preventing SMH nurses from completing thorough assessments to include admission assessments, wound care, PICC line care, and notifying the RN or provider for any abnormal changes in patient condition as well as documenting accurately. Leadership should implement remedial measures as appropriate.

- Leadership should develop and implement strategies to ensure all staff activate the 9-1-1 system immediately for emergent patients needing a higher level of care.

- Nursing leadership should determine the root cause of challenges to SMH patients receiving all ordered medications within the required time frame and should implement remedial measures as appropriate.

Specialty Services

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's performance in providing needed specialty care. We also examined specialty appointment scheduling, providers' specialty referrals, and medical staff's retrieval, review, and implementation of any specialty recommendations.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Inadequate* (64.8%)**

Case review found CHCF needed improvement with specialty services. Patients inconsistently received timely access to specialty appointments, as we identified significant delays. In addition, while providers frequently reviewed specialty reports within required time frames, we identified patterns of deficiencies involving staff untimely retrieving and scanning reports, staff not forwarding reports to the providers, and providers delaying endorsing reports or not endorsing the reports at all. In considering all factors, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing revealed mixed results in this indicator. Staff performed satisfactorily in providing high-priority specialty appointments timely. However, medium-priority and routine-priority specialty services intermittently occurred within required time frames. Retrieving specialty reports and prompt provider endorsements only occasionally occurred timely. Based on the overall **Specialty Services** compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 363 events related to specialty services, 302 of which were specialty consultations and procedures, and 40 were nursing encounters. We identified 80 deficiencies in this category, 39 of which were significant.[76]

Access to Specialty Services

CHCF performed variably in providing timely access to specialists. Compliance testing showed high-priority (MIT 14.001, 80.0%) specialty appointments usually occurred timely, but medium-priority (MIT 14.004, 66.7%) and routine-priority (MIT 14.007, 73.3%) specialty appointments only sometimes occurred timely. Additionally, preapproved specialty services for newly arrived patients only intermittently occurred within required time frames (MIT 14.010, 50.0%).

[76] Deficiencies occurred in cases 2, 3, 5, 11, 12, 14-16, 18-23, 26, 27-35, and 36. Severe deficiencies occurred in cases 2, 3, 5, 11, 15, 16, 18-22, 26- 29, 31, 33-35, and 36.

OIG clinicians identified 17 deficiencies with specialty care access, 14 of which were significant.[77] The following are examples:

- In case 20, the provider ordered a vascular surgery specialty follow-up appointment. However, the appointment did not occur as ordered.
- In case 27, a hematology specialty follow-up appointment occurred 12 days late.[78]
- In case 29, the podiatrist recommended a one-month follow-up appointment for the patient. However, the appointment did not occur as ordered.
- In case 36, the patient underwent an off-site, high-priority ultrasound-guided biopsy appointment. However, this appointment occurred 18 days late.

We also discuss specialty service access in the **Access to Care** indicator.

Provider Performance

CHCF offered good access to providers after specialty service appointments. Compliance testing showed timely provider follow-up appointments occurred frequently (MIT 1.008, 79.1%). Similarly, OIG clinicians identified only two late provider follow-up appointments, one of which was significant:[79]

- In case 2, the patient returned from an off-site ophthalmology specialty appointment for a preoperative cataract surgery consultation, after which the patient was scheduled to have a follow-up appointment with a CHCF provider within five calendar days. However, this appointment occurred six days late.

We also found providers generally ordered appropriate specialty consultations, followed specialty recommendations, and performed appropriate specialty follow-up assessments. We identified two deficiencies related to provider care, one of which was significant.[80]

We discuss these deficiencies further in the **Provider Performance** indicator.

Nursing Performance

CHCF nurses performed satisfactorily in assessing patients who returned to the facility from off-site specialty appointments. OIG clinicians identified 13 deficiencies, two of which were significant:[81]

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[77] Specialty care access deficiencies occurred in cases 3, 12, 18-20, 22, 27, 29, 33, 35, and 36. Significant deficiencies occurred in cases 3, 18, 19, 20, 22, 27, 29, 33, 35, and 36.

[78] Hematology is the field of medicine related to the diagnosis, management, and treatment of blood disorders.

[79] Deficiencies in access to provider follow-up after specialty services occurred in cases 2 and 36. A significant deficiency occurred in case 2.

[80] Deficiencies related to provider care occurred in cases 18 and 22. A significant deficiency occurred in case 18.

[81] Deficiencies related to nursing care occurred in cases 2, 12, 15, 22, 23, 26, and 29. Significant deficiencies occurred in cases 2 and 29.

- In case 2, the patient returned from an off-site ophthalmology specialty appointment. The nurse did not contact the specialist for recommendations, complete the appropriate documentation, or schedule a follow-up appointment with the CHCF provider.

- In case 29, the patient returned from an off-site surgery specialty appointment for right foot debridement and graft. The nurse did not contact the CHCF provider to obtain new wound care orders, order a CHCF provider follow-up appointment, or complete the appropriate documentation.

We also discuss these deficiencies in the **Nursing Performance** indicator.

Health Information Management

CHCF performed variably in managing specialty reports. CHCF staff performed excellently in scanning specialty reports timely (MIT 4.002, 96.7%). However, compliance testing revealed staff received, and providers endorsed, routine-priority (MIT 14.008, 66.7%) and high-priority (MIT 14.002, 66.7%) specialty reports intermittently with the required time frame. Similarly, compliance testing revealed staff received, and providers endorsed, medium-priority (MIT 14.005, 40.0%) service reports sporadically within the required time frame. OIG clinicians identified 46 CHCF health information management (HIM) deficiencies, 13 of which were significant.[82] The following are examples:

- In case 5, staff scanned a pacemaker evaluation report 110 days late into the EHRS.

- In case 15, staff did not forward an oncology specialty report to the provider for endorsement.

- In case 31, staff scanned a urology specialty report 27 days late into the EHRS.

- In case 33, staff scanned a pathology report from a bone marrow biopsy 29 days late into the EHRS

We also discuss management of health records in the **Health Information Management** indicator.

Clinician On-Site Inspection

The OIG clinicians discussed management of specialty reports with the health information management (HIM) supervisors and the supervising registered nurses (SRNs), who managed the off-site, utilization management, on-site, and telemedicine services. The SRNs reported checking specialty service orders in the EHRS and scheduling appointments based on the priority of the orders and the compliance date. To keep track of the orders, they utilized the quality management (QM) report to generate daily reports on appointment data. Management cited the specialty providers' appointment availabilities and patients being out of the institution for higher level of

[82] HIM deficiencies occurred in cases 2, 3, 5, 11, 14-16, 19, 21, 22, 26-35, and 36. Significant deficiencies occurred in cases 2, 3, 5, 11, 15, 16, 21, 22, 26-28, 31, 33, and 34.

care as challenges in maintaining the compliance dates. The SRNs reported difficulty in obtaining specialty appointments for orthopedics, cardiology, neurosurgery, and neurology. They reported no staff shortages during the review period. They conveyed utilizing staff trained in the specialty in order to support regular staff when they are off.

Compliance Score Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	12	3	0	80.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	6	3	6	66.7%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	6	9	0	40.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	2	2	11	50.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	4	2	9	66.7%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	10	10	0	50.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	12	5	0	70.6%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	12	3	2	80.0%
				Overall percentage (MIT 14): 64.8%

Source: The Office of the Inspector General medical inspection results.

Table 18. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	34	9	2	79.1%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	29	1	15	96.7%

* CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical leadership should determine the root cause(s) of challenges to staff timely providing initial specialty appointments and their subsequent follow-up appointments and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) of challenges for staff timely retrieving and scanning specialty reports, as well as providers timely endorsing specialty reports, and should implement necessary remedial measures.

Administrative Operations

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, our inspectors determined whether the institution provided training and job performance reviews for its employees. We checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score. Our case review clinicians do not rate this indicator.

Because none of the tests in this indicator directly affected clinical patient care (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (61.7%)**

CHCF's performance was mixed in this indicator. While CHCF scored excellently in some applicable tests, it needed improvement in multiple areas. The EMRRC only sporadically completed the required checklists. In addition, staff conducted medical emergency response drills with incomplete documentation and missing required emergency response drill forms. Physician managers did not complete any annual performance appraisals timely. The nurse educator did not ensure all newly hired nurses received the required onboarding training. Lastly, the nurse educator did not ensure all nurses who administer medications complete their clinical competency testing timely. These findings are set forth in the table on the next page. Based on the overall **Administrative Operations** compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

At CHCF, the OIG did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001).

We obtained CCHCS Mortality Case Review reporting data. In our inspection, for nine patients, we found no evidence in the submitted documentation the preliminary mortality reports had been completed. These reports were overdue at the time of the OIG's inspection. For one patient, the compliance date was outside of our testing period (MIT 15.998).

Compliance Score Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	2	10	0	16.7%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	1	3	0	25.0%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	9	1	0	90.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	7	3	0	70.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	34	0	0
Did the providers maintain valid state medical licenses? (15.106)	41	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	2	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information.			
				Overall percentage (MIT 15): 61.7%

Source: The Office of the Inspector General medical inspection results.

Recommendations

The OIG offers no recommendations for this indicator.

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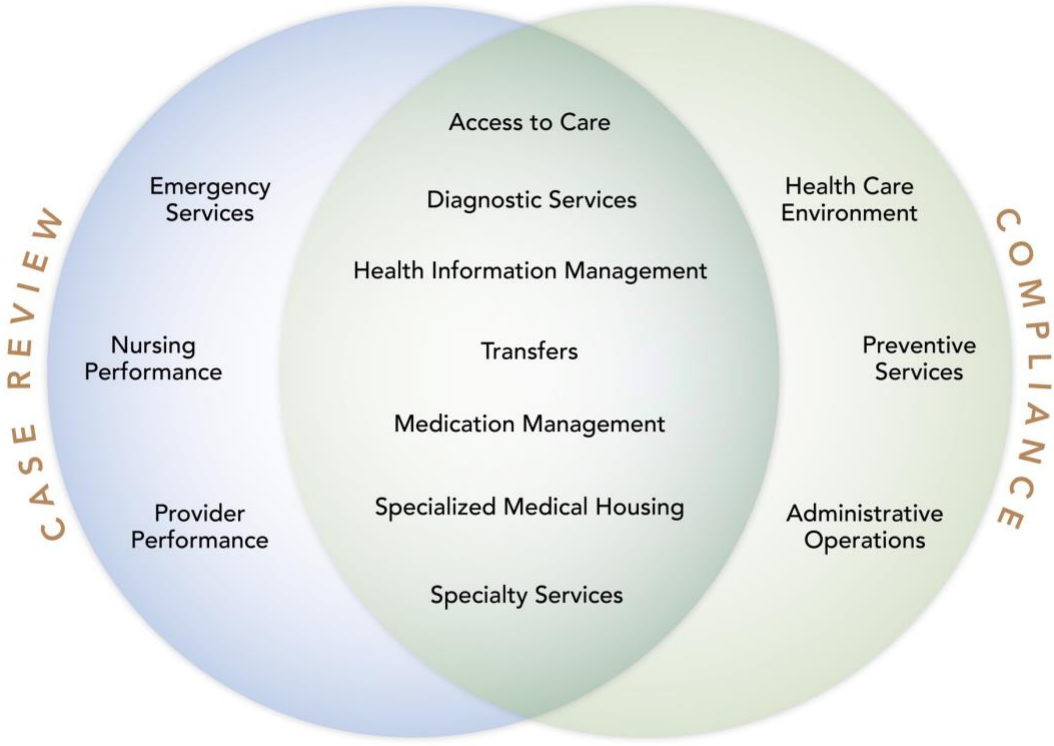
Appendix A: Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the receiver's office, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Review Distribution for CHCF



Source: The Office of the Inspector General medical inspection results.

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 7 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinical analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

For most basic institutions, the OIG samples 20 comprehensive physician review cases. For institutions with larger high-risk populations, 25 cases are sampled. For the California Health Care Facility, 30 cases are sampled.

Case Review Sampling Methodology

We obtain a substantial amount of health care data from the inspected institution and from CCHCS. Our analysts then apply filters to identify clinically complex patients with the highest need for medical services. These filters include patients classified by CCHCS with high medical risk, patients requiring hospitalization or emergency medical services, patients arriving from a county jail, patients transferring to and from other departmental institutions, patients with uncontrolled diabetes or uncontrolled anticoagulation levels, patients requiring specialty services or who died or experienced a sentinel event (unexpected occurrences resulting in high risk of, or actual, death or serious injury), patients requiring specialized medical housing placement, patients requesting medical care through the sick call process, and patients requiring prenatal or postpartum care.

After applying filters, analysts follow a predetermined protocol and select samples for clinicians to review. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

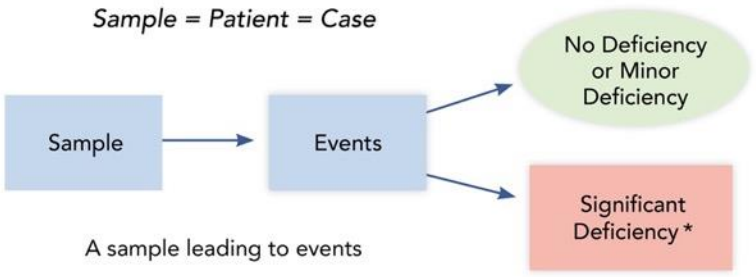
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we refer to as case review ***deficiencies***.

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an ***adverse event***. On the next page, Figure A–2 depicts the possibilities that can lead to these different events.

After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.

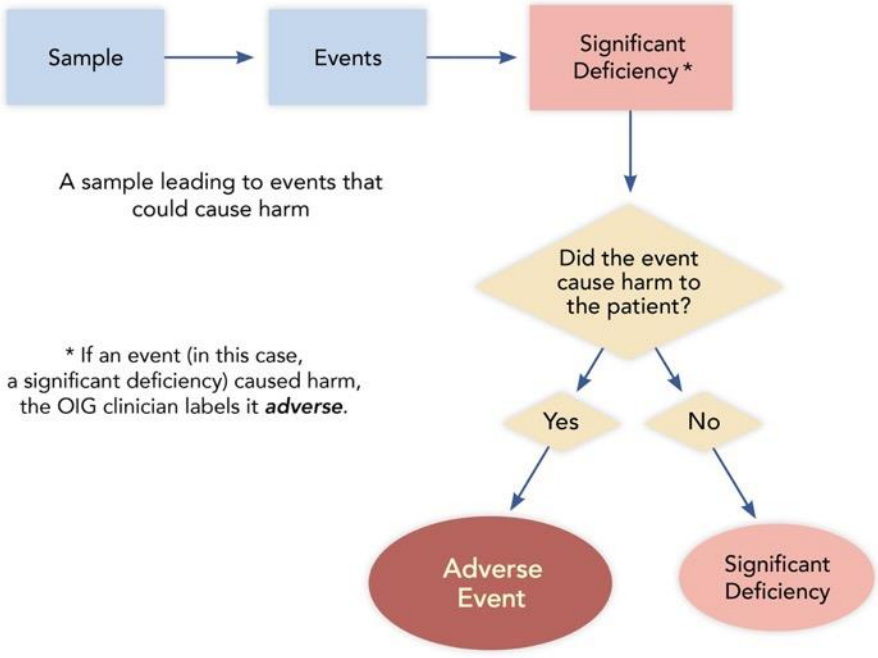
Figure A–2. Case Review Testing

The OIG clinicians examine the chosen samples, performing either a ***comprehensive case review*** or a ***focused case review***, to determine the events that occurred.



Deficiencies

Not all events lead to deficiencies (medical errors); however, if errors did occur, then the OIG clinicians determine whether any were ***adverse***.



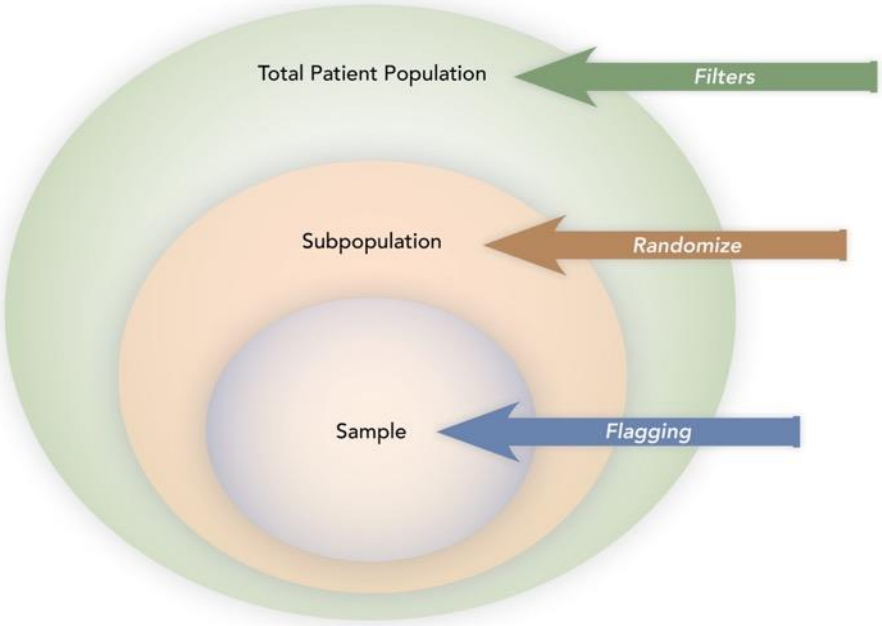
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

Figure A–3. Compliance Sampling Methodology



Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing Methodology

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a ***Yes*** or a ***No*** answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other documents, and obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

Our compliance team calculates the percentage of all Yes answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

The OIG medical inspection unit individually examines all the case review and compliance inspection findings under each specific methodology. We analyze the case review and compliance testing results for each indicator and determine separate overall indicator ratings. After considering all the findings of each of the relevant indicators, our medical inspectors individually determine the institution's overall case review and compliance ratings.

Appendix B: Case Review Data

Table B–1. CHCF Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	25
Specialty Services	5
	67

Table B–2. CHCF Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	13
Anticoagulation	13
Arthritis/Degenerative Joint Disease	13
Asthma	13
Cancer	8
Cardiovascular Disease	13
Chronic Kidney Disease	17
Chronic Pain	14
Cirrhosis/End-State Liver Disease	9
Coccidioidomycosis (Valley Fever)	3
COPD	7
COVID-19	4
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	23
Gastroesophageal Reflux Disease (GERD)	26
Hepatitis C	15
Hyperlipidemia	40
Hypertension	46
Mental Health	21
Migraine Headaches	2
Seizure Disorder	5
Sleep Apnea	7
Substance Abuse	11
Thyroid Disease	10
	336

Table B–3. CHCF Case Review Events by Program

Diagnosis	Total
Diagnostic Services	509
Emergency Care	129
Hospitalization	122
Intrasystem Transfers In	10
Intrasystem Transfers Out	6
Outpatient Care	316
Specialized Medical Housing	692
Specialty Services	438
	2,222

Table B–4. CHCF Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	31
MD Reviews Focused	3
RN Reviews Detailed	20
RN Reviews Focused	38
Total Reviews	92
Total Unique Cases	67
Overlapping Reviews (MD & RN)	25

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Appendix C: Compliance Sampling Methodology

California Health Care Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	23	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	23	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	23	CADDIS off-site admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	40	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	0	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	23	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intrafacility Moves	0	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	2	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	25	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	N/A at this institution	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	3	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	3	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	22	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	17	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	34	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	41	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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March 30, 2026

Amarik Singh, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

California Correctional Health Care Services has reviewed the draft Medical Inspection Report for California Health Care Facility conducted by the Office of the Inspector General from July 2024 to December 2024. Thank you for preparing the report.

If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F6B95AC0A4D1...

DeAnna Gouldy
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Sarah Hartmann, Chief Counsel, CCHCS Office of Legal Affairs
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
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Cycle 7

Medical Inspection Report

for

California Health Care Facility

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
April 2026

OIG