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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

June 2026

Salinas Valley State Prison

Medical Inspection Report

Cycle 8

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Contents

Illustrations

Tables

Figures

Photographs

Introduction

Pursuant to California Penal Code section 6126, subdivision (f), 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 8, the OIG continues to apply similar assessment methodologies used in Cycle 7; however, we incorporated several important changes in our inspection process for this cycle. As with the two previous cycles, we continue to review institutional care using the same 15 indicators,[3] and our inspection methodologies still include both clinical case review and compliance testing.

Specifically, 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 systemic errors, and we examine whether the institution's medical system mitigated the error. Our clinicians also perform on-site inspections, which include interviews with staff.

In contrast, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in our medical inspection tool (MIT). The OIG determines a total compliance score for each applicable indicator and considers the MIT scores in the overall determination of the institution's compliance performance.

Together, these methods assess the institution's medical care on both individual and systemic 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. Similarly to Cycle 7, the OIG separately rates the institution's health care delivery through both our clinical case review and compliance testing for each applicable indicator as ***proficient***, ***adequate***, or ***inadequate***, and considers each rating in determining the case review and compliance overall ratings of the institution's health care performance. We found this change in Cycle 7 clarified the distinctions between these differing quality measures and the results of each assessment.

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[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.

In addition to assessing individual institutions in Cycle 7, the OIG also completed analyses of cross-institution and cross-cycle trends to update and enhance our inspection process. Through these analyses, we made the following changes to enhance the accuracy and value of our oversight. First, we identified a correlation between low case review ratings for health care staff performance during emergency responses and low compliance testing scores relating to training and preparing institutional staff for emergency responses and institutions internally assessing those responses. Thus, to better focus on each institution's emergency care, we created a new compliance test component for **Indicator 3. Emergency Services** to supplement the case review findings under this indicator. In the compliance component of the **Emergency Services** indicator, we relocated four compliance tests relating to emergency services that previously existed in **Indicator 5. Health Care Environment** and **Indicator 15. Administrative Operations**.[4] Second, we updated our compliance tests in accordance with the department's policy changes and pursuant to discussions with our stakeholders. Third, we updated our case review sampling in response to stakeholder requests by increasing the number of death reviews, adding evaluation of specialized medical housing encounters within the detailed provider case reviews, and adjusting our case samples to align with current medical practices.[5]

As we did during Cycle 7, the OIG continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. Our statutory mandate provides no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. However, in recognition of the state's interest in the care being provided at the undelegated institutions, the OIG scheduled the medical inspections of the three remaining undelegated institutions earlier in our Cycle 8 inspection calendar.[6] At the time of the Cycle 8 inspection of Salinas Valley State Prison, the receiver had not yet delegated the institution back to the department.

[4] The following four tests were each relocated to MIT 3. Emergency Services: (1) MIT 5.111 testing emergency response bags and treatment carts, (2) MIT 15.003 testing the Emergency Medical Response Review Committee (EMRRC) meeting minutes, (3) MIT 15.101 testing the institution's required quarterly emergency response drills for each watch with both custody and health care staff, and (4) MIT 15.107 testing the institution's compliance with maintaining up to date basic life support (BLS), advanced cardiac life support (ACLS), and cardiopulmonary resuscitation (CPR) certifications for health care and custody staff. These four tests now comprise all the tests contained within new compliance MIT 3.

[5] Some of the changes in our compliance and case review inspections included (1) separating previously compound compliance test questions, which allows us to identify more clearly which components of the test the institution is performing well from components that require improvement, and (2) amending several compliance testing and case review methodologies in a variety of indicators to more closely align with clarifications regarding the department's policies, as well as updates in general medical practice, such as new anticoagulation treatment trends.

[6] The three remaining undelegated institutions are listed on the CCHCS website fact sheet available here: https://cchcs.ca.gov/factsheet/.

Summary: Ratings and Scores

We completed the Cycle 8 inspection of Salinas Valley State Prison (SVSP) in December 2025.[7] OIG inspectors monitored the institution's delivery of medical care that occurred during the specified review periods.[8]

The OIG rated the case review component of the overall health care quality at SVSP as ***adequate***.

The OIG rated the compliance component of the overall health care quality at SVSP as ***adequate*** (75.1%).

OIG case review clinicians—a team of Physicians & Surgeons (physicians) and Nursing Consultants, Program Review (NCPRs)—reviewed 48 cases, which contained 1,088 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 February 2026 to verify their initial findings. OIG clinicians evaluated the quality of care for a total of 60 case reviews that included both physician and NCPR comprehensive detailed case reviews and focused case event reviews.[9]

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. OIG case review clinicians identify deficiencies and adverse events to highlight

[7] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The general inspection period includes samples from June 2025 to December 7, 2025, as well as on-site observations during January 2026 and February 2026; however, the OIG may review samples outside the general inspection period as dictated by our methodologies. The case reviews include emergency non-CPR reviews between December 2024 and May 2025, and death reviews between December 2024 and October 2025.

[8] Samples are obtained per our medical inspection methodologies shared with stakeholders in prior cycles. The general inspection period includes samples from June 2025 to December 7, 2025, as well as on-site observations during December 2025 and February 2026; however, the OIG may review samples outside the general inspection period as dictated by our methodologies. The case reviews include emergency non-CPR reviews between December 2024 and May 2025, and death reviews between December 2024 and October 2025.

[9] For our detailed and focused case reviews, our clinicians reviewed medical charts and events for 48 unique patients. Both physicians and NCPRs reviewed 12 of those cases, for a total of 60 detailed and focused case reviews.

concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10]

To evaluate the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies set forth in the department's Health Care Department Operations Manual (HCDOM)[11] by applying a standardized set of test questions that measure specific elements of health care delivery as required under the HCDOM. Our compliance inspectors examined 398 patient records and 1,237 data points, and we used the data to assess 101 MIT questions. We also observed SVSP's processes during an on-site inspection in January 2026.

The OIG then considered the results from both our clinical case review and compliance testing, and we determined our individual indicator findings and the institution's overall ratings for each component, which we report in 13 health care indicators.[12]

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

[11] The department's Health Care Department Operations Manual (HCDOM) is available here: https://www.cdcr.ca.gov/hcdom/dom/.

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

Overall Medical Inspection Results

Case Review Results

OIG case reviewers assessed 10 of the 13 indicators applicable to SVSP. OIG clinicians rated three of these 10 indicators ***proficient***, six ***adequate***, and one ***inadequate***. In the 1,088 events reviewed, we identified 288 deficiencies, 50 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm. We solely tested **Nursing Performance** and **Provider Performance** in clinical case review as these indicators do not have a compliance component.

Adverse Events Identified During Case Review

The OIG did not find any adverse events at SVSP during the Cycle 8 inspection.

Compliance Testing Results

Our compliance inspectors assessed 11 of the 13 indicators applicable to SVSP. Of these 11 indicators, our compliance inspectors rated three ***proficient***, four ***adequate***, and four ***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.

We list the individual indicators and ratings applicable for this institution in Table 1 on the following page.

Table 1. SVSP 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

MIT Number	Health Care Indicators	Case Review		Compliance		
		Cycle 8	Change Since Cycle 7*	Cycle 8	Cycle 7	Change Since Cycle 7*
1	Access to Care	Proficient	↑	83.3%	86.7%	↓
2	Diagnostic Services	Adequate	=	73.3%	60.0%	=
3	Emergency Services	Inadequate	↓	40.3%	N/A	N/A
4	Health Information Management	Adequate	=	91.9%	89.3%	=
5	Health Care Environment	N/A	N/A	81.5%	55.7%	↑
6	Transfers	Proficient	↑	82.8%	73.6%	↑
7	Medication Management	Proficient	↑	61.3%	62.5%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	86.1%	69.3%	↑↑
10	Nursing Performance	Adequate	=	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	Adequate	N/A	57.1%	67.9%	=
14	Specialty Services	Adequate	=	75.7%	73.2%	↑
15	Administrative Operations	N/A	N/A	92.3%	68.8%	↑↑

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 7 and Cycle 8. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level (e.g., inadequate to adequate, proficient to adequate, etc.), and the double arrow means the rating rose or fell two levels (e.g., from inadequate to proficient or from proficient to inadequate).

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Institution-Specific Metrics

Salinas Valley State Prison (SVSP) is located in the city of Soledad in Monterey County. The institution opened in 1996. The institution operates four main medical clinics and treats patients needing urgent or emergent care in its triage and treatment area (TTA). SVSP also treats patients who require a higher level of inpatient care in the institution's correctional treatment center (CTC). SVSP is currently identified as a "*basic*" institution, which refers to institutions located in more rural areas, away from significant tertiary community hospitals and medical specialists. As such, these institutions are generally expected to treat fewer high-risk patients and more patients with less complex care needs.[13]

On November 10, 2025, the Health Care Services Master Registry showed SVSP had a total population of 2,503. A breakdown of the medical risk level of the SVSP population as determined by the department is set forth in Table 2 below.[14]

Table 2. SVSP Master Registry Data as of November 2025

Medical Risk Level	Number of Patients	Percentage*
High 1	252	10.1%
High 2	307	12.3%
Medium	1,219	48.7%
Low	725	29.0%
Total	**2,503**	**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 November 10, 2025.

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, SVSP had no vacant executive leadership positions, 5.0 primary care provider vacancies, 0.5 nursing supervisor vacancies, and 20.8 nursing staff vacancies.

[13] Institutions designated as "*basic*" are generally expected to have a high-risk medical population of approximately 5%. At over 22%, SVSP's high risk population is more than four times the expected ratio. However, this institution is still assigned a medical staffing package consistent with its *basic* designation. This discrepancy between SVSP's designation and patient complexity may account in part for some deficiencies we identified.

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

Table 3. SVSP Health Care Staffing Resources as of November 2025

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	9.0	32.5	214.6	261.1
Filled by Civil Service	5.0	4.0	32.0	193.8	234.8
Vacant	0.0	5.0	0.5	20.8	26.3
Percentage Filled by Civil Service	100.0%	44.4%	98.5%	90.3%	89.9%
Filled by Telemedicine	0.0	0.0	0.0	0.0	0.0
Percentage Filled by Telemedicine	0.0%	0.0%	0.0%	0.0%	0.0%
Filled by Registry	0.0	1.0	0.0	26.0	27.0
Percentage Filled by Registry	0.0%	11.1%	0.0%	12.1%	10.3%
Total Filled Positions	5.0	5.0	32.0	219.8	261.8
Total Percentage Filled	100.0%	55.6%	98.5%	102.4%	100.3%
Appointments in Last 12 Months	0.0	0.0	0.0	55.1	55.1
Redirected Staff	0.0	0.0	0.0	0.0	0.0
Staff on Extended Leave‡	0.0	0.0	1.0	9.0	10.0
Adjusted Total: Filled Positions	5.0	5.0	31.0	210.8	251.8
Adjusted Total: Percentage Filled	100.0%	55.6%	95.4%	98.2%	96.4%

* 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 8 medical inspection pre-inspection questionnaire received on November 12, 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 8. 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 SVSP'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)—SVSP'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. SVSP had a 33 percent influenza immunization rate for adults 18 to 64 years old and a 53 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal immunization rate was 90 percent.

Cancer Screening

Statewide comparative data was available for colorectal cancer screening. When compared with statewide Medi-Cal programs— California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)— SVSP had a 59 percent colorectal cancer screening rate, a rate higher and thus better than California Medi-Cal but lower than both Kaiser Southern California (Medi-Cal) and Kaiser Northern California (Medi-Cal).

Table 4. SVSP Results Compared to State HEDIS Scores

HEDIS Measure	SVSP Cycle 8 Results*	California Medi-Cal†	Kaiser NorCal Medi-Cal†	Kaiser SoCal Medi-Cal†
Diabetes Care				
Poor HbA1c Control (>9.0%) ‡, §	**10%**	33%	26%	19%
HbA1c Control (<8.0%) ‡	80%	–	–	–
Blood Pressure Control (<140/90) ‡	93%	–	–	–
HbA1c Screening	89%	–	–	–
Eye Exams	69%	–	–	–
Immunizations				
Influenza - Adults (18–64)	33%	–	–	–
Influenza - Adults (65+)	53%	–	–	–
Pneumococcal – Adults (65+)	90%	–	–	–
Cancer Screening				
Colorectal Cancer Screening	59%	40%	**71%**	**71%**

* Unless otherwise stated, data were collected in December 2025 by reviewing medical records from a sample of SVSP'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 California Department of Health Care Services Medi-Cal Managed Care Physical Health 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 SVSP population was tested.

§ For this measure only, a lower score is better. The best scores in each comparable category are indicated in green.

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

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.

Access to Care: Case Review Ratings and Results Summary

In this cycle, case review found SVSP performed excellently overall in delivering access to care for its patients, similar to Cycle 7. Staff performed very well in timely access to providers in specialized medical housing (SMH), follow-up after hospitalizations, emergency care, specialty services, and after transfer into SVSP. Patients also received excellent access to clinic nurses. One of the only two significant deficiencies we identified in this indicator related to a late provider clinic appointment, while the other related to a specialty services appointment. Considering all aspects of access to care, the OIG rated the case review component of this indicator ***proficient***.

Case Review Results

Table 5. Case Review Access to Care Results

Total Cases Reviewed*	Deficiencies†	Significant Deficiencies‡
49	7	2

* The OIG reviewed 49 cases.

† Deficiencies occurred in cases 18, 20, 23, 33, and 49.

‡ Significant deficiencies occurred in cases 20 and 33.

Performed Well

OIG clinicians found SVSP performed well in the following areas:

- Access to SMH Providers[15]
- Access to Clinic Nurses[16]
- Follow-up After Specialty Services[17]
- Follow-up After Hospitalizations[18]
- Follow-up After Urgent or Emergent Care[19]
- Follow-up After Transferring into SVSP[20]

Performed Satisfactorily, with Opportunities for Improvement

OIG clinicians found SVSP performed satisfactorily with opportunities for improvement in the following areas:

- Access to Clinic Providers

  Providers usually evaluated patients within specified time frames as ordered. OIG clinicians identified one significant deficiency, as follows:

  - In case 20, the provider determined the patient needed a follow-up appointment within five days due to continued swelling from cellulitis.[21] However, this appointment occurred 10 days late.

- Access to Specialty Services

  Specialty appointments usually took place within the requested time frames. We identified two deficiencies related to access to specialty services, one of which was significant.[22] We discuss this further in the **Specialty Services** indicator.

Performed Poorly, Improvement Needed

OIG clinicians found no areas in this indicator in which SVSP performed poorly.

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[15] A minor deficiency in access to SMH providers occurred in case 49.

[16] OIG clinicians identified no deficiencies in this sub-indicator.

[17] A minor deficiency in provider follow-up access after a specialty service appointment occurred in case 18.

[18] OIG clinicians identified no deficiencies in this sub-indicator.

[19] Two minor deficiencies in TTA follow-up access occurred in cases 20 and 23.

[20] OIG clinicians identified no deficiencies in this sub-indicator.

[21] Cellulitis is a skin and soft tissue infection caused by bacteria.

[22] Deficiencies in specialty services access occurred in case 33. One of these deficiencies was significant.

Clinician On-Site Inspection

SVSP has four main clinics: Facilities A, B, C, and D. A and D Facilities have two teams, Red and Blue, each with a patient care team. Providers also deliver care for patients in restricted housing unit (RHU), transitional care units (TC1 and TC2), TTA, and CTC.[23] The CTC building houses the CTC unit with 24 beds (12 medical and 12 mental health), TTA, on-site specialty clinics, pharmacy, diagnostic services (laboratory and imaging), dietary service, and health care administration.

Photo 1. Facility D clinic. Photographed 2-19-26.

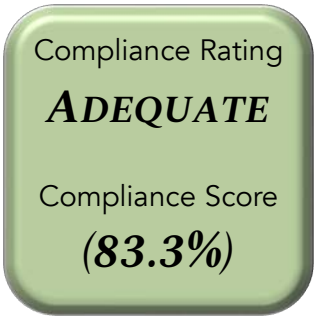
Medical leadership and providers expressed challenges with provider backlogs mainly due to the restrictions with patient movements as directed by the daily program status report (PSR) from frequent violent disturbances on the yards that disrupted the daily operations. During the PSR restrictions, custody staff needed more time to individually escort patients within proper security protocols to health care appointments. OIG clinicians observed the morning huddles were well attended by the patient care team, ancillary staff, and the health care access (HCA) custody officer, who updated patient movements on that day.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

[23] TC1 and TC2 consist of mental health beds.

Access to Care: Compliance Ratings and Results Summary



SVSP performed well in this indicator. Based on the overall compliance score result of 83.3 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- Upon arrival at the institution, providers maintained a consistent workflow, completing comprehensive patient appointments for 22 of 25 patients (MIT 1.002, 88.0%). For three patients, the appointments occurred six and 19 days late.
- Following the review of patients' submitted health care services request forms (CDCR 7362), registered nurses achieved perfect compliance by completing face-to-face appointments for all 30 patients within one business day (MIT 1.004, 100%).
- In 11 applicable samples in which a registered nurse identified the need for a primary care referral, 10 patients were seen within the required time frame (MIT 1.005, 90.9%) according to the priority level assigned to their appointment. For one patient, the record contained no evidence the primary care provider (PCP) appointment occurred within our review period.
- The institution attained a perfect score in ensuring all follow-up provider sick call appointments occurred within the specific time frames ordered by the primary care provider (MIT 1.006, 100%).
- Providers completed post-discharge follow-up appointments for 23 of 25 sampled patients within the required time frame (MIT 1.007, 92.0%). For one patient, the appointment occurred one day late. For the remaining patient, the record contained no evidence that a refusal form was completed within our review period.
- The institution implemented a standardized process for the acquisition and submission of health care services request forms, ensuring a consistent process for all patients and resulting in a perfect score (MIT 1.101.2, 100%).

SVSP performed in the ***adequate*** range in the following sub-indicator:

- The institution ensured most recent chronic care appointments were conducted for 19 of 25 sampled patients within the specified time frame (MIT 1.001, 76.0%). For five patients, the appointments occurred between six and 182 days late. For the remaining patient, the record contained no evidence that a refusal form was completed within our review period.

SVSP performed in the ***inadequate*** *range* in the following sub-indicators:

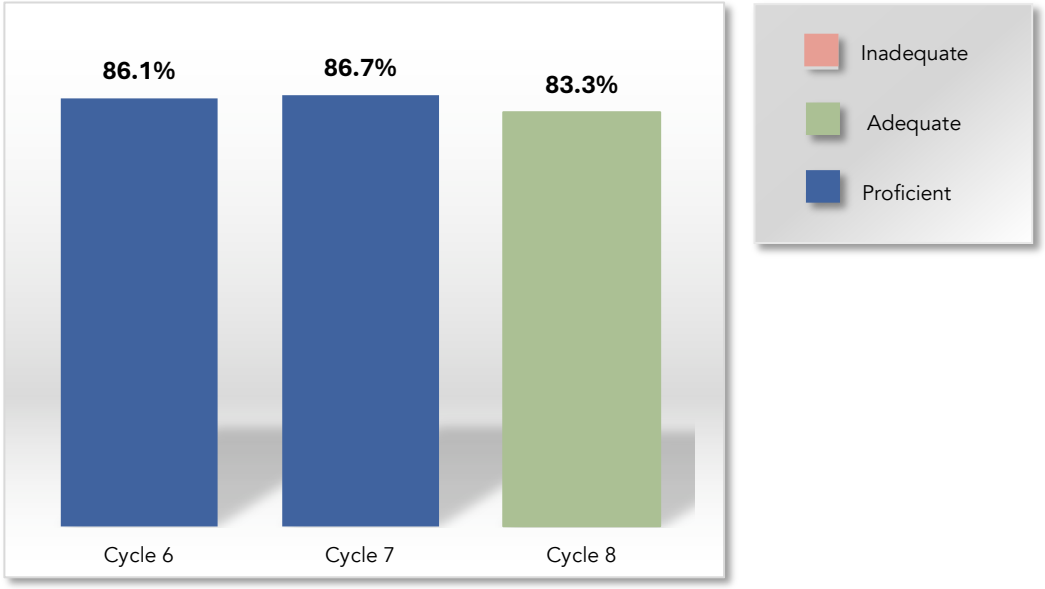
- Nursing staff performed poorly in adhering to triage documentation standards; only nine of 30 sampled patients met the full requirements for a completed review upon receipt of the health care services request form (MIT 1.003, 30.0%). For 21 patients, nursing staff failed to accurately complete the form with the required printed or stamped name, title, and signature.
- The institution intermittently met mandated timelines for provider follow-up appointments for patients returning from specialty services. Furthermore, in cases involving medium- or routine-priority specialty services in which a patient was not seen, the primary care team (PCT) only provided the required timely notification of the specialist recommendation in 30 of 41 sampled patients (MIT 1.008, 73.2%). For five patients, the PCP follow-up appointment after a high-priority specialty service occurred between three and 11 days late. For four patients with medium- and routine-priority specialty service appointments, the record contained no evidence the PCP either completed the appointment or generated a patient letter outlining specific specialty recommendations as required by policy. For one patient, the PCP follow-up appointment after a medium-priority specialty service occurred 10 days late. For the remaining patient, the record contained no evidence of a PCP appointment following a high-priority specialty service within our review period.

The following test is not scored but is reported for informational purposes:

- The institution implemented a standardized process for the replenishment of health care services request forms in which custody officers coordinate through the program office to ensure an adequate supply is maintained for all patients. However, a few housing units continued to rely on medical staff to replenish these forms (MIT 1.101.1, N/A).

Analysis of Performance Across Inspection Cycles

Figure 1. Access to Care, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

SVSP consistently exceeded the 75.0 percent compliance threshold, maintaining a strong performance of 83.3 percent in Cycle 8. Although this demonstrates a slight decline from SVSP's peak performance of 86.7 percent in Cycle 7, the institution remains firmly ahead of established standards for access to care.

Compliance Score Results

Table 6. Access to Care Compliance Test Scores

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)	19	6	0	76.0%
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)	22	3	0	88.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	9	21	0	30.0%
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)	30	0	0	100%
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)	10	1	19	90.9%
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	0	29	100%
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)	23	2	0	92.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? For medium- or routine-priority specialty service appointments: If the patient was not seen, did the PCT inform the patient of the recommendations within the required time frame? (1.008)	30	11	4	73.2%
For informational purposes only: Do custody staff members have a system in place to replenish health care services request forms? (1.001.1)	0	0	6	N/A
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101.2)	6	0	0	100%
Overall percentage (MIT 1): **83.3%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- Nursing leadership should develop strategies to ensure nurses properly process medical requests (CDCR Form 7362) and complete all required documentation. Leadership should implement and monitor remedial measures as appropriate.

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 test reports and whether providers reviewed the results timely.

Diagnostic Services: Case Review Ratings and Results Summary

In this cycle, case review found SVSP performed satisfactorily with diagnostic services. Staff often timely completed laboratory and radiology tests. Additionally, providers endorsed results within the specified time frames. However, similar to Cycle 7, providers often either did not send or sent incomplete test result notification letters to patients. After considering all aspects, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 7. Case Review Diagnostic Services Results

Diagnostic Events*	Deficiencies†	Significant Deficiencies‡
156	56	3

* The OIG reviewed 156 events.

† Deficiencies occurred in cases 1, 2, 8–11, 13–20, 22–23, 32, and 33. Of these 56 deficiencies, 54 related to health information management, and two related to delays in diagnostic test completion.

‡ Significant deficiencies occurred in cases 1, 18, and 20.

Performed Well

OIG clinicians found no areas in this indicator in which SVSP performed well.

Performed Satisfactorily, with Opportunities for Improvement

OIG clinicians found SVSP performed satisfactorily with opportunities for improvement in the following area:

- Test Completion

  Staff generally completed laboratory and imaging diagnostic tests timely. However, OIG clinicians identified two significant deficiencies related to completing diagnostic tests:

  - In case 1, the provider ordered a CBC laboratory test to be performed. However, staff did not complete the test.[24]
  - In case 18, the provider ordered a foot x-ray for a patient. However, staff did not complete the x-ray.

Performed Poorly, Improvement Needed

OIG clinicians found SVSP performed poorly, with improvement needed in the following area:

- Health Information Management

  SVSP performed variably in managing the results of diagnostic tests. Although providers usually timely endorsed laboratory and imaging results, we identified a significant pattern of deficiencies in which, following diagnostic tests, providers generated patient notification letters missing one of the required four components per CCHCS policy or did not send a result letter at all.[25] The following are examples:

  - In case 10, the provider ordered blood and urine tests for a patient with diabetes. However, the provider endorsed the laboratory tests one day late and did not send the patient a test result notification letter.
  - In case 13, the patient received a chest x-ray for upper respiratory symptoms. The provider endorsed the test result but did not send the patient a test result notification letter.

[24] A CBC is a complete blood count laboratory test. The test measures the red blood cells, hemoglobin, white blood cells, and platelets.

[25] Notably, 53 health information management deficiencies were related to patient notification letters missing some of the required elements, being sent late to the patient, or not being sent at all. These 53 deficiencies occurred in cases 2, 8–11, 13–19, 22, 23, 32, and 33.

Clinician On-Site Inspection

OIG clinicians met with SVSP's chief support executive (CSE), correctional health services administrator (CHSA), senior laboratory assistant, and phlebotomists. The senior assistant described the laboratory testing workflow, including the collection and processing of regular and STAT laboratory collections in the clinics and TTA. OIG clinicians also met with two contracted radiology technologists and an office technician (OT). SVSP offered digital x-rays and on-site mobile imaging services for CT, ultrasound, and FibroScan every two weeks.[26] The leadership expressed challenges in recruiting permanent radiology technologists, and the institution currently employs contracted temporary technologists to meet the needs of imaging requests.

Photo 2. Laboratory collection tray.
Photographed 2-19-26.

Photo 3. Radiology x-ray machine.
Photographed 2-19-26.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

[26] 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 patients for liver scarring and fatty changes from liver disease.

Diagnostic Services: Compliance Ratings and Results Summary

SVSP's performance presented several opportunities for improvement in this indicator. Based on the overall compliance score result of 73.3%, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- Providers demonstrated proficiency in reviewing and endorsing radiology reports for nine of 10 sampled patients (MIT 2.002, 90.0%). For one patient, the ordering health care provider did not endorse the report.
- Laboratory services consistently completed all orders within the specified time frames (MIT 2.004, 100%).
- Providers demonstrated proficiency in reviewing and endorsing laboratory reports for nine of 10 sampled patients (MIT 2.005, 90.0%). For one patient, the provider endorsed the report three days late.
- SVSP received pathology reports for all sampled patients within required time frames (MIT 2.010, 100%).
- Providers demonstrated proficiency in reviewing and endorsing pathology reports for nine of 10 sampled patients (MIT 2.011, 90.0%). For one patient, the provider endorsed the report 31 days late.

SVSP performed in the ***adequate*** range in the following sub-indicators:

- The institution's radiology staff delivered sufficient diagnostic services for eight of 10 sampled patients within required time frames (MIT 2.001, 80.0%). For two patients, the high-priority radiology service order was not performed timely.

SVSP performed in the ***inadequate*** range in the following sub-indicators:

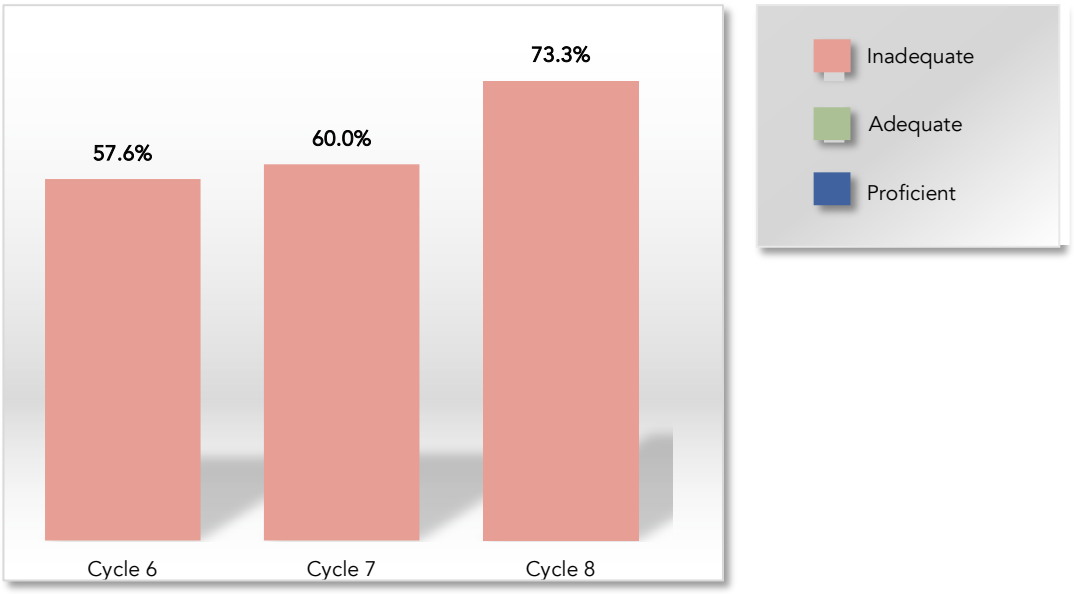
- Healthcare providers generated patient notification letters for radiology reports with all required elements within specified time frames for five of 10 sampled patients (MIT 2.003, 50.0%), indicating a significant need for improvement. For three patients, the record contained no evidence of a generated patient letter communicating radiology

results. For two patients, the patient letters were missing key elements as required by policy.

- Healthcare providers generated patient notification letters for laboratory reports with all required elements within specified time frames for six of 10 sampled patients (MIT 2.006, 60.0%), indicating a significant need for improvement. For three patients, the patient letters were missing key elements as required by policy. For one patient, the letter was generated three days late.
- Healthcare providers did not generate any compliant patient notification letters for pathology laboratory results within specified time frames for all 10 sampled patients (MIT 2.012, zero). For four patients, we found no evidence of a generated patient letter communicating pathology results. For three patients, the letters were generated between three and 13 days late. For the remaining three patients, the patient letters were missing key elements as required by policy.

Analysis of Performance Across Inspection Cycles

Figure 2. Diagnostic Services, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

The institution performed below established standards for diagnostic services, highlighting several opportunities for improvement in communicating patient results. Overall, the institution did not meet the 75.0 percent compliance threshold for diagnostic services, reaching only 73.3 percent in Cycle 8. However, the performance over the past three cycles demonstrates steady improvement in this indicator from 57.6 percent in Cycle 6 and 60.0 percent in Cycle 7 to nearly adequate performance in Cycle 8.

Table 8. Diagnostic Services Compliance Test Scores

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? Effective 09/2025: Did the health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Radiology: Did the ordering health care provider generate the patient notification letter with all the required elements within the specified time frame? Effective 09/2025: Did the health care provider generate the patient notification letter with all required elements within the specified time frame? (2.003)	5	5	0	50.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the health care provider generate the patient notification letter with all the required elements within the specified time frame? (2.006)	6	4	0	60.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
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)	9	1	0	90.0%
Pathology: Did the health care provider generate the patient notification letter with all required elements within the specified time frame? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **73.3%**

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- The department should develop, implement, and monitor solutions, such as an electronic solution, to ensure providers timely communicate radiology, laboratory, and pathology results to patients containing all required elements for explaining diagnostic results.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of urgent and emergent medical care. Our clinicians reviewed these events 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, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the healthcare leadership's ability to identify opportunities for improvement in the emergency medical response review process.

Emergency Services: Case Review Ratings and Results Summary

In this cycle, OIG clinicians found SVSP's overall performance needed improvement in emergency services. We found healthcare and custody staff responded promptly to emergency events throughout the institution, and providers made appropriate triage decisions. However, we determined nurses needed improvement in nursing assessments, interventions, and documentation during emergency events. We also identified patterns of delayed or incomplete provider documentation of TTA events. Additionally, clinical reviews were often incomplete or not completed at all. When clinical reviews were conducted, nursing and medical leadership did not always identify the same training opportunities as the OIG clinicians. Factoring all the information, the OIG rated this indicator ***inadequate***.

Case Review Results

Table 9. Case Review Emergency Services Results

Urgent or Emergent Events*	Deficiencies†	Significant Deficiencies‡
134	93	10

* Urgent or emergent events occurred in cases 1–11, 18–23, and 33.

† Deficiencies occurred in cases 1–5, 8–10, 16, 18–23, and 25.

‡ Significant deficiencies occurred in cases 1, 2, 5, 9, 20, and 22.

Performed Well

OIG clinicians found no areas in this indicator in which SVSP performed well.

Performed Satisfactorily, with Opportunities for Improvement

OIG clinicians found SVSP performed satisfactorily with opportunities for improvement in the following areas:

- Emergency Medical Response

  We found SVSP healthcare and custody staff responded promptly to urgent and emergent events. However, we identified two significant deficiencies in which nurses delayed contacting emergency medical services (EMS) during emergency events. The following are examples:

  - In case 9, the TTA nurse responded to a medical alarm for a patient with complaints of shortness of breath, mild sweating, dizziness, abnormally low oxygen saturation rate, a critically elevated blood pressure reading, and an elevated heart rate. However, we identified a delay in activating EMS for nine minutes. During our on-site interviews, the institution agreed with the deficiency.

  - In case 22, staff activated an emergency medical alarm for a patient with altered level of consciousness. The patient was transferred to the TTA, where he reported falling off his lower bunk and hitting his head. The provider ordered the patient to be transferred to the community hospital; however, staff did not contact EMS until 32 minutes after the provider ordered the transfer. During our on-site interviews, the institution agreed with the deficiency.

- Cardiopulmonary Resuscitation Quality[27]

  Nurses generally initiated CPR immediately; however, nurses occasionally did not implement appropriate nursing interventions during the CPR. The following are examples:

  - In case 5, custody staff initiated CPR and administered two doses of Narcan. The first medical responder, an LVN, arrived at the patient with CPR in progress. However, the LVN did not initiate positive pressure ventilation.[28] The LVN inappropriately placed a non-rebreather mask when the patient was not breathing instead of initiating breaths through an Ambu bag with oxygen.[29] Additionally, the LVN checked for a radial pulse; however, the LVN should have checked for a carotid or femoral pulse for a patient receiving CPR.

[27] We reviewed CPR events in cases 3–8, 10, and 11. CPR deficiencies occurred in cases 3, 4, 5, and 10. Significant deficiencies occurred in case 5.

[28] Positive Pressure Ventilation (PPV) is a method of assisting a person to breathe by actively pushing air into the lungs, rather than relying on the patient's muscles to pull air in, which is how people normally breathe.

[29] A non-rebreather mask is an oxygen mask that delivers high concentrations of oxygen and is used when a person can breathe on their own but needs a lot of oxygen quicky.

- In case 10, custody staff activated an emergency medical alarm and initiated CPR for the unconscious patient with a suspected drug overdose. The healthcare first responders assessed the patient, provided medical care, and administered five doses of naloxone.[30] However, nursing staff did not perform a blood glucose check or document the doses of naloxone administered on the medication administration record (MAR).

Performed Poorly, Improvement Needed

OIG clinicians found SVSP performed poorly with improvement needed in the following areas:

- Nursing Performance in Assessments and Interventions[31]

  OIG clinicians found SVSP needed improvement in nursing assessments and interventions. Our clinicians found nurses frequently performed incomplete assessments, failed to initiate appropriate interventions, and often did not reassess patients when the patient's condition warranted. The following are examples:

  - In case 1, nurses responded to a medical emergency for this patient, who complained of shortness of breath with a severe low oxygen saturation reading on room air. While in the care of the TTA nurse, the patient continued to have severe low oxygen saturation readings with oxygen provided at two liters per minute via nasal cannula.[32] However, the nurse did not reassess the patient's oxygen saturation reading or intervene by applying the appropriate amount of oxygen.

  - In case 2, nurses responded to a medical alarm for this patient with chest pain, and dizziness. The patient reported inserting marijuana and cocaine into the rectum. The patient was transported to the community hospital. However, the TTA nurses did not continuously monitor the patient on a cardiac monitor until EMS arrived. Additionally, the nurses did not monitor the patient's vital signs in the TTA for 40 minutes until EMS arrived.

  - In case 19, custody staff activated a medical emergency alarm for a patient with an altered level of conscious. The healthcare first responder LVN arrived and noted the patient was vomiting and had altered level of consciousness. The patient had an elevated blood pressure and heart rate, but breathing was normal. The TTA RN arrived at the patient, and the patient reported intermittent chest

[30] Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose. According to the manufacturer, nasal naloxone doses can be safely administered every two to three minutes. CCHCS emergency medical training allows nurses to administer five nasal naloxone doses when an opioid overdose is suspected.

[31] Nursing performance deficiencies occurred in cases 1–5, 8–10, 19, 20, 22 and 23. Significant deficiencies occurred in cases 1, 2, 5, 9, and 22.

[32] A nasal cannula is a flexible plastic tube that delivers extra oxygen directly into the nostrils.

pain and dizziness. The patient was transported to the TTA, and the nurse contacted the provider and received orders for electrocardiogram (EKG), medications for stomach discomfort, and a urine test for the following day.[33] The patient returned to the housing unit in stable condition. However, the healthcare first responder LVN did not document the description of the vomit. Additionally, the TTA RN did not assess for abdominal tenderness, conduct orthostatic blood pressures, reassess vital signs, including elevated heart rate, or assess the patient's pain level prior to discharge to the housing unit.[34]

- In case 22, staff activated a medical emergency alarm for a patient with altered level of consciousness. The healthcare first responder RN arrived, administered one dose of naloxone, and the patient became alert and oriented. The patient was transported to the TTA, where the patient reported falling from his lower bunk and hitting his head. The nurse contacted the provider, and the patient was transferred to the community hospital. However, the TTA nurse did not contact the provider until 30 minutes after the patient's arrival to the TTA. Additionally, the nurse did not initiate cervical spine immobilization or assess the patient's neurological status every 15 minutes.[35]

- Nursing Performance in Documentation[36]

  OIG clinicians found nurses needed significant improvement in nursing documentation during emergency responses. Our clinicians identified patterns of incomplete documentation of nursing assessments and missing medication administration record (MAR) documentation. We also identified a pattern of timeline discrepancies related to the sequence of events. The following are examples:

  - In case 1, the provider evaluated the patient in the TTA and ordered a respiratory treatment. However, the nurse did not document whether the patient received the respiratory treatment prior to transfer to the community hospital.

  - In case 2, at 9:43 p.m., nursing staff responded to a medical alarm for this patient, who complained of chest pain. The nurse contacted the provider and received orders to administer stomach medication and observe the patient in TTA for 30 minutes prior to discharging the patient back to housing. The RN documented notifying the provider at 10:36 p.m. However, the nurse also documented the patient was discharged to housing at 9:52 p.m., and the patient was offered and

[33] An EKG is an electrocardiogram. This non-invasive test measures and records the electrical impulses from the heart and is used to help diagnose heart problems.

[34] Orthostatic blood pressures mean the blood pressure and pulse measurements are recorded in three separate positions: laying down, sitting, and standing. Positive orthostatic is when these measurements are abnormal, indicating possible fluid loss.

[35] Cervical spinal immobilization is when healthcare staff stabilize the neck to prevent movement and further injuries.

[36] Documentation deficiencies occurred in cases 1, 9, 16, 18–23, and 25.

refused the medication at 10:25 p.m., which is both 33 minutes after the patient was documented to have discharged back to the housing unit as well as 11 minutes prior to the provider notification in which the RN received the order to administer this medication.

  - In case 8, staff activated a medical emergency alarm for a patient involved in an altercation. The LVN responded and noted the patient had a stab wound to the back. The TTA RN arrived 10 minutes later and transferred the patient to the TTA. However, the LVN did not obtain a full set of vital signs and did not document whether the patient had any active bleeding. The TTA RN documented the patient had a laceration above the eye and puncture wound to the mid upper back but did not document the size or description of the wounds to include description of any active bleeding.

- Provider Performance

  SVSP has one provider covering the TTA during normal working hours. An on-call provider was available for consultation during after-hours. The providers were available when TTA nurses requested consultation and generally made appropriate triage decisions. However, the providers performed poorly in documenting TTA events, as we identified 20 deficiencies related to late or missing documentation of TTA events.[37] An example is below:

  - In case 19, the TTA nurse consulted the on-call provider for a patient with altered mental status and chest pain. The provider ordered an EKG, pain reliever medicines, and a urine test. However, the provider did not document a progress note.

- Emergency Medical Response Review Process

  Our clinicians reviewed 52 emergency events in which patients transferred to a higher level of care to include patient deaths. We identified 27 deficiencies in which nursing and medical leadership did not conduct the clinical reviews, or the reviews were incomplete.[38] Additionally, when clinical reviews were conducted, the institution did not identify the same opportunities for improvement as the OIG clinicians. The following are examples:

  - In case 1, nursing and medical leadership did not conduct a clinical review for the emergency event involving this patient, who transferred to the community hospital for complaints of breathing problems. Similar deficiencies occurred in cases 2 and 19.

[37] Documentation deficiencies occurred in cases 1, 9, 16, 18–23, and 25.

[38] Clinical review deficiencies occurred in cases 1–3, 5, 8–10, 19, 22, and 23. Significant deficiencies occurred in cases 5 and 22.

- In case 3, the supervising registered nurse (SRN) conducted a clinical review for a patient with stab wounds, who transferred to the community hospital. However, the SRN did not identify the same opportunities for improvement the OIG clinicians identified. Similar deficiencies occurred in cases 1, 2, 5, 8, 9, and 10.

- In cases 1 and 3, the SRN completed clinical reviews for the emergency events. However, neither the chief nurse executive (CNE) nor the chief medical executive (CME) conducted their clinical reviews of the event.

Clinician On-Site Inspection

During the on-site inspection, the OIG clinicians interviewed the TTA nursing staff. The TTA had three bays. During first, second, third watch, two RNs were assigned each shift. In addition, a third RN was assigned from 12 p.m. to 8 p.m. TTA nursing staff reported RNs rotate responsibility for responding to medical emergencies.

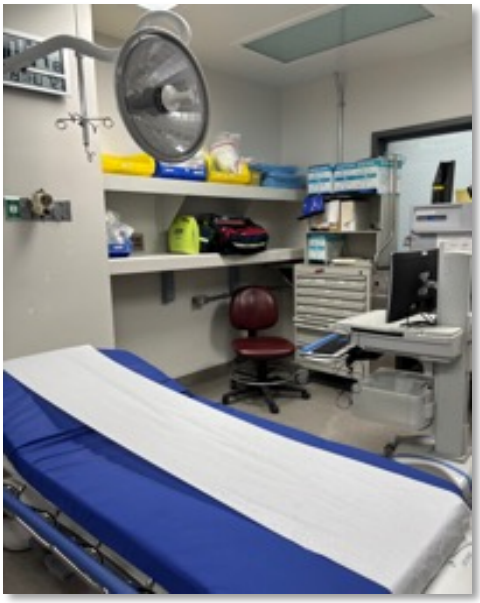


Photo 4. TTA treatment room. Photographed 2-19-26.

During the on-site inspection, two yards had restricted patient movement, requiring patients to be escorted by custody staff to their medical appointments. Nursing staff and leadership reported SVSP experiences frequent restricted patient movement on C and D yards. Nursing staff reported an increase in emergency medical alarms during this period of restricted movement. For example, in December 2025, the RNs reported 792 emergency medical alarms as well as 126 patients who required transfer to the community hospital for a higher level of care.

The OIG clinicians interviewed nursing leadership to discuss the OIG case review findings regarding multiple incomplete or missing clinical reviews for emergency events. At the on-site inspection, nursing leadership and quality management staff reported clinical reviews were lost when "emergency packets" were hand delivered for signature to the executive leadership or designee. Nursing leadership reported the clinical review process is now completed electronically and routed to appropriate staff for review through an electronic signature process. Since implementation of this electronic process, leadership reported all clinical reviews are now completed and signed by the required executive leadership, and the reviews are no longer misplaced or lost. At the time of our inspection, SVSP was still working through their backlog for clinical reviews that occurred during the OIG review period of SVSP cases. However, they reported they do not have a backlog for current clinical reviews for February 2026.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure nurses perform complete assessments, provide interventions, and thoroughly document their actions to include all appropriate timelines. Leadership should implement and monitor remedial measures as appropriate.
- Healthcare leadership should develop, implement, and monitor strategies to ensure both the CME or designee and the CNE or designee complete clinical reviews for emergency events and accurately document both their findings and all identified opportunities for improvement. Leadership should implement and monitor remedial measures as appropriate.

Emergency Services: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(40.3%)

SVSP performed poorly on this indicator, as the institution's results were consistently lacking and fell significantly below the testing threshold. Based on the overall compliance score, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- SVSP achieved a perfect compliance score in maintaining current certifications for cardiopulmonary resuscitation (CPR), basic life support (BLS), and advanced cardiac life support (ACLS) (MIT 3.105, 100%).

SVSP performed in the ***inadequate*** range in the following sub-indicators:

- The Emergency Medical Response Review Committee (EMRRC) reviewed cases in a timely manner and ensured incident packages included all required documents for only three of 12 sampled patients (MIT 3.001, 25.0%), primarily due to incomplete checklists and untimely reviews for nine patients.
- Nursing staff inspected and inventoried emergency medical response bags (EMRB) and ensured they contained all essential items for only two of eight applicable clinical areas (MIT 3.101, 25.0%). For six EMRBs, we found one or more of the following deficiencies: staff failed to ensure bag compartments were sealed and intact; medical supplies were found compromised (see Photo 5, right); staff did not inventory the bags when the seal tags were replaced (see Photo 6, below); and several EMRB daily glucometer quality control logs were either incomplete or inaccurate.

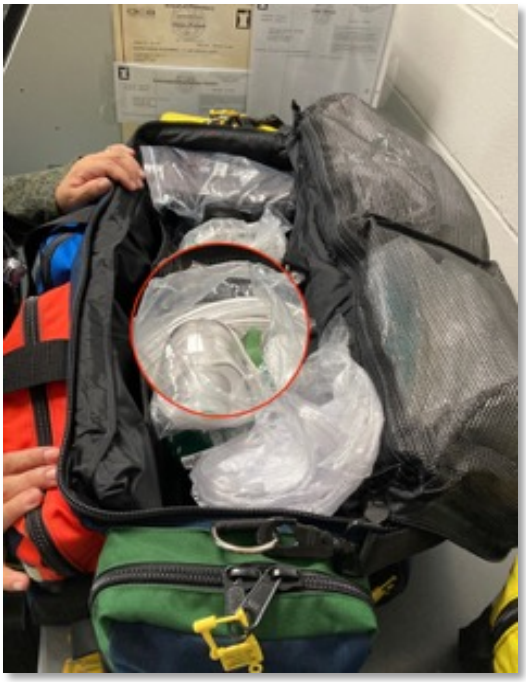


Photo 5. Compromised medical supplies contained in EMRB.
Photographed 1-5-2026.

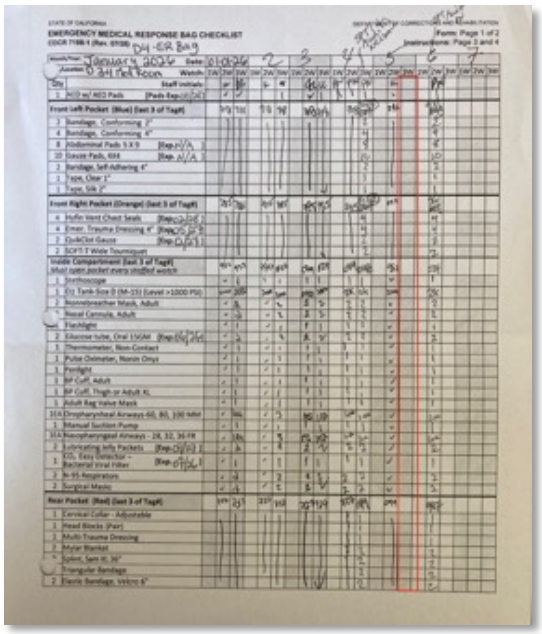

EMERGENCY MEDICAL RESPONSE BAG CHECKLIST

Photo 6. Incomplete EMRB inventory log. Photographed 1-6-2026.

evidence of a completed inventory within the last 30 days (see Photo 7, right).

- The institution conducted medical emergency response drills during each watch of the most recent quarter. However, the required checklists were incomplete for all three watch drills, resulting in a score of zero (MIT 3.104, zero). The emergency drill packet had missing documentation that is required to be completed during mock code, and the checklist was missing documentation of required time frames for all elements.

- Nursing staff inspected and inventoried treatment carts within the required time frames for only one of four applicable clinical areas (MIT 3.102, 25.0%). For three treatment carts, we found one or more of the following deficiencies: staff failed to maintain and complete a daily security check for the most recent 30 days; treatment cart seal security check log documentation was incomplete; and a treatment cart was not secured with a red tamper-resistant seal at the time of inspection.

- Nursing staff inspected and inventoried disaster response bags within the required time frames for four of six applicable clinical areas (MIT 3.103, 66.7%). For two clinics, disaster response bag logs contained no

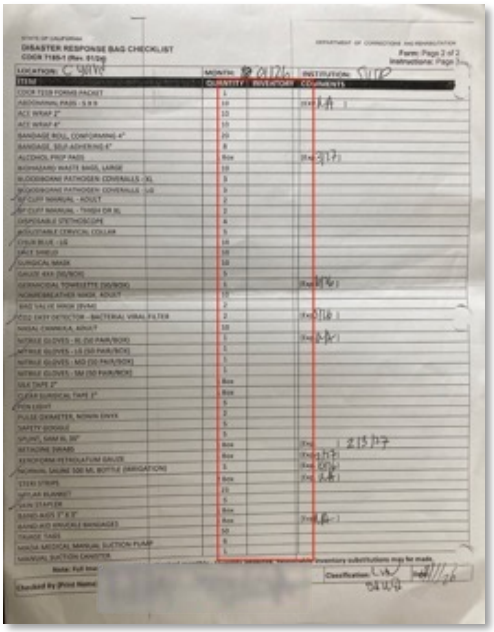
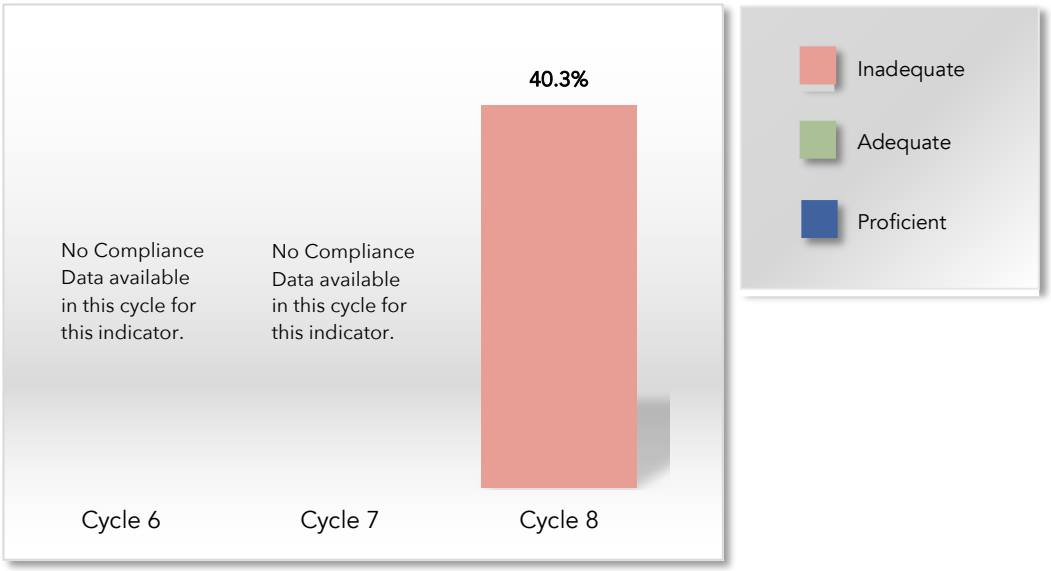

DISASTER RESPONSE BAG CHECKLIST

Photo 7. Incomplete disaster bag checklist. Photographed 1-6-2026.

Analysis of Performance Across Inspection Cycles

Figure 3. Emergency Services, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

The institution performed below established standards for emergency response and coordination, highlighting significant opportunities for improvement. Specifically, the institution did not meet the 75.0 percent compliance threshold for emergency services readiness, reaching only 40.3 percent in Cycle 8.

Notably, while we conducted these individual emergency compliance tests in prior cycles, we relocated these tests in Cycle 8 to this new indicator. Thus, no prior cycle data is available for indicator comparison. However, we include below the cycle comparisons for each individual test, which indicates continuing excellent scores in MIT 3.105, improvement in MIT 3.001, regression in MITs 3.101 and 3.102, and continuing poor scores in MIT 3.104.

Table 10. Emergency Services, Compliance Scores across Cycles by Test

Cycle 8 MIT Test Number	Cycle 6 Scores	Cycle 7 Scores	Cycle 8 Scores
MIT 3.001	33.3 %	8.3 %	25.0 %
MIT 3.101 & 3.102	66.7 %	57.1%	MIT 3.101 25.0 % MIT 3.102 25.0 %
MIT 3.104	100 %	0.0 %	0.0 %
MIT 3.105	100 %	100 %	100 %

Notes: Cycle 8 MIT 3.001 was previously tested under Cycles 6 and 7 as MIT 15.003. Cycle 8 MIT 3.101 and 3.102 were previously tested together under Cycles 6 and 7 as MIT 5.111. Cycle 8 MIT 3.104 was previously tested under Cycles 6 and 7 as MIT 15.101. Cycle 8 MIT 3.105 was previously tested under Cycles 6 and 7 as MIT 15.107. Cycle 8 MIT 3.103, testing disaster bags, is a new test with no comparable data from prior cycles and is excluded from this table.

Table 11. Emergency Services Compliance Test Scores

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the case timely, and did the incident packages reviewed include the required documents? (3.001)	3	9	0	25.0%
Clinical areas: Are emergency medical response bags inspected and inventoried within required timeframes, and do they contain essential items? (3.101)	2	6	3	25.0%
Clinical areas: Are treatment carts inspected and inventoried within required timeframes? (3.102)	1	3	7	25.0%
Clinical areas: Are disaster response bags inspected and inventoried within required timeframes? (3.103)	4	2	5	66.7%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did the health care and custody staff participate in those drills? (3.104)	0	3	0	0
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advance Cardiac Life Support (ACLS) certifications? (3.105)	2	0	1	100%
Overall percentage (MIT 3): **40.3%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- Health care leadership should develop, implement, and monitor strategies to ensure nursing supervisors thoroughly complete the emergency medical response review checklists and nursing staff inspect and inventory EMRBs, treatment carts, and disaster response bags in accordance with CCHCS policy.

Health Information Management (HIM)

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 the institution's clinicians appropriately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

HIM: Case Review Ratings and Results Summary

In this cycle, case review found SVSP performed satisfactorily in health information management (HIM). SVSP staff retrieved hospital records timely and performed well with managing emergent records and scanning medical documents. We identified late scanning of specialty reports and incomplete or missing patient test result notification letters. Taking all factors into consideration, the OIG rated the case review component of this indicator adequate.

Case Review Results

Table 12. Case Review HIM Results

Events*	Deficiencies†	Significant Deficiencies‡
1,089	73	2

*The OIG reviewed 1,089 events.

† Deficiencies occurred in cases 2, 8–11, 13–20, 22, 23, 32–33, and 49.

‡ Significant deficiencies occurred in cases 13 and 20.

Performed Well

OIG clinicians found SVSP performed well in the following areas:

- Hospital Reports[39]
- Urgent and Emergent Records[40]
- Scanning Performance[41]

Performed Satisfactorily, with Opportunities for Improvement

OIG clinicians found SVSP performed satisfactorily with opportunities for improvement in the following area:

- Specialty Reports

  OIG clinicians identified 15 minor deficiencies related to managing specialty services reports.[42] Most of these related to scanning reports late into the EHRS in four cases.[43] In three deficiencies, the providers endorsed reports two to 10 days late. We identified one significant deficiency, as follows:

  - In case 13, SVSP staff scanned the nephrology report into the EHRS, but the provider did not endorse the report until one month later, a significant delay.

Performed Poorly, Improvement Needed

OIG clinicians found SVSP performed poorly with improvement needed in the following area:

- Diagnostic Reports

  SVSP performed variably in managing the results of diagnostic tests. Although providers almost always timely endorsed laboratory and imaging results, we identified 54 minor deficiencies in 17 cases related to diagnostic information management, with the overwhelming majority due to incomplete or unsent patient test result notification

[39] A minor deficiency occurred in case 23 related to staff not sending an emergency department report for a provider review and endorsement.

[40] OIG clinicians identified no deficiencies in this sub-indicator.

[41] A minor deficiency occurred in case 23 related to a mislabeled report.

[42] Specialty report health information management deficiencies occurred in cases 13, 14, 17, 20, 32, 33, and 49.

[43] Scanning deficiencies occurred in cases 14, 17, 32, and 33. 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 the department's correctional system.

letters. In addition, we also identified one significant deficiency related to a late diagnostic report result retrieval, as follows:[44]

- In case 20, the patient was sent to the hospital for a chest x-ray. SVSP staff retrieved the report 25 days later, a significant delay.

Please refer to the **Diagnostic Services** indicator for more information.

Clinician On-Site Inspection

OIG clinicians discussed health information management processes with the chief support executive (CSE), correctional health services administrator (CHSA), medical records supervisor, health records technicians (HRTs), and providers. The medical records supervisor described the workflow and explained the process to retrieve and upload off-site specialty consultation reports, hospital reports, and telemedicine specialty reports into the EHRS. TTA nursing staff scan the reports into the EHRS when patients return from the off-site specialists' appointments, emergency encounters, and hospital encounters. The HRTs divide their workload by the patients' numbers and track patients' encounters with off-site specialists and hospitals using their spreadsheet and logs from the TTA, specialty service appointments, patient hospitalizations, telemedicine appointments. Office assistants (OAs) pick up health records from the yards and bring them to HIM for scanning.

Photo 8. Entrance door to the HIM unit. Photographed 2-23-26.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

[44] Diagnostic report health information management deficiencies occurred in cases 2, 8–11, 13–20, 22–23, 32, and 33.

HIM: Compliance Ratings and Results Summary

In this indicator, SVSP's performance demonstrated proficiency in timely scanning specialty reports and correctly labeling documents. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

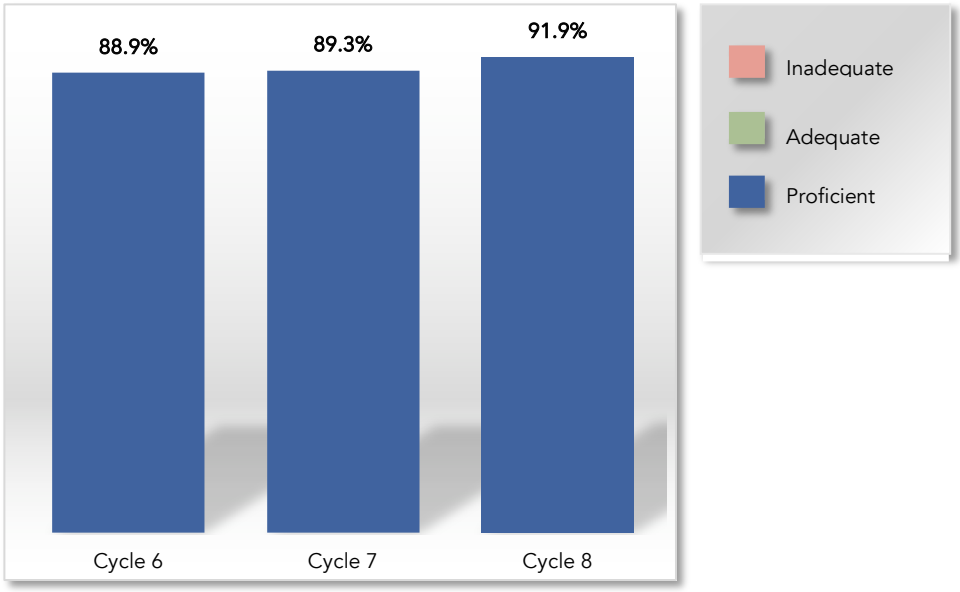
- The institution achieved a perfect compliance rate for the timely integration of health care services request forms (CDCR 7362) into the electronic health record system (EHRS). Staff scanned all documented forms within the required time frames, ensuring immediate data availability for the patient care team (MIT 4.001, 100%).
- The institution demonstrated strong operational proficiency, ensuring community hospital discharge documents were scanned into the patients' EHRS within required time frames for 18 of 20 sampled patients (MIT 4.003, 90.0%). For two patients, staff scanned the reports one and 10 days late.
- The institution labeled and scanned records into the patients' records for all 25 sampled patients (MIT 4.004, 100%).
- The institution exhibited exceptional proficiency ensuring the provider reviewed and endorsed community hospital discharge reports within five calendar days of discharge for 24 of 25 sampled patients (MIT 4.005, 96.0%). For one patient, the provider reviewed the report three days late.

SVSP performed in the ***inadequate*** range in the following sub-indicators:

- The institution exhibited opportunities for improvement in ensuring staff scanned specialty notes into patients' EHRS in accordance with established timelines for 22 of 30 patients (MIT 4.002, 73.3%). For eight patients, staff scanned the specialty reports between one and 14 days late.

Analysis of Performance Across Inspection Cycles

Figure 4. Health Information Management, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: http://www.oig.ca.gov/.

In Cycle 8, SVSP's performance surpassed the 75.0 percent compliance threshold for health information management (HIM), reaching 91.9 percent in Cycle 8. This rating represents a continued upward trajectory from the previous proficient scores of 88.9 percent in Cycle 6 and 89.3 percent in Cycle 7, indicating the institution has developed a successful process to maintain performance well above the minimum established standards for HIM.

Table 13. Health Information Management Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within one calendar day of the patient 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)	22	8	15	73.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	18	2	5	90.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	25	0	0	100%
For patients discharged from a community hospital: Did a provider review and endorse the report within five calendar days of discharge? (4.005)	24	1	0	96.0%
Overall percentage (MIT 4): **91.9%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- Health care leadership should identify the root cause(s) of challenges in timely scanning specialty documents into the patient's file. Leadership should implement and monitor remedial measures as appropriate.

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.

In Cycle 7, the OIG did not include the score or rating for this indicator in the institution's overall compliance assessment. However, beginning with Cycle 8, the OIG determined adherence to health care environment requirements should be considered a primary factor because these requirements ensure the health care environments are sufficiently conducive to providing good medical care. Therefore, this indicator's individual score is included in the institution's overall compliance rating.

Health Care Environment: Compliance Ratings and Results Summary

Compliance Rating
ADEQUATE
Compliance Score
(81.5%)

SVSP met the required benchmarks acceptably during this inspection cycle. Based on the overall compliance score result of 81.5 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- The institution demonstrated very good performance in maintaining a clean and sanitary environment for 10 of 11 clinical health care areas and ensuring staff consistently updated the corresponding cleaning logs for all 11 clinics (MIT 5.101.2, 90.9% and MIT 5.101.3, 100%). In one clinic, inspectors identified an uncleaned floor along with a chair and sink that were in disrepair (see Photo 9, right).

Photo 9. Sink in disrepair. Photographed 1-5-2026.

- The institution achieved perfect performance in ensuring reusable non-invasive medical equipment is properly disinfected as warranted for all 11 clinical health care areas (MIT 5.102.2, 100%).
- Ten of 11 clinics ensured clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies (MIT 5.103, 54.5%). In one clinic, the staff restroom lacked disposable towels.
- The institution attained perfect performance in ensuring clinical health care areas control exposure to blood-borne pathogens and contaminated waste for all 11 clinics (MIT 5.105, 100%).
- The institution's medical warehouse delivered exceptional performance in ensuring the medical supply management process adequately supports the needs of the medical health care program (MIT 5.106, 100%).
- The institution sustained outstanding performance in ensuring the environments in the common clinical and nonclinical areas are conducive to providing medical services for all 11 clinics (MIT 5.109.1, 100% and MIT 5.109.2, 100%).
- The institution upheld superior performance in ensuring the clinic examination rooms have adequate space and remain free of clutter to provide medical services for all 11 clinics (MIT 5.110.1, 100% and MIT 5.110.2, 100%).

SVSP performed in the ***adequate*** range in the following sub-indicators:

- The institution maintained sufficient performance in ensuring clinic examination rooms have working computer stations, well-maintained furniture, and accessible medical equipment for nine of 11 clinics (MIT 5.110.3, 81.8%). For two clinics, we found the following deficiencies: the examination chair had torn vinyl cover (see Photo 10, below); and a drawer was found in disrepair (see Photo 11, below).

Photo 10. Vinyl cover of chair in disrepair. Photographed 1-5-2026.

Photo 11. Drawer in disrepair. Photographed 1-5-2026.

SVSP performed in the ***inadequate*** range in the following sub-indicators:

- The institution failed to meet performance standards for ensuring reusable invasive medical equipment was properly sterilized or disinfected as warranted for all applicable sampled clinics (MIT 5.102.1, zero).
- Only three of six medical staff observed ensured adherence to universal hand hygiene precaution, in which staff follows proper handwashing protocols (MIT 5.104, 50.0%). In three clinics, clinicians did not wash or sanitize their hands before each subsequent regloving, or before and after physically touching the patient.
- Only five of 11 clinics ensured adequate management and storage of bulk medical supplies (MIT 5.107, 45.5%). Specific deficiencies for six clinics included: lack of clear labeling or misalignment of labels (see Photo 12, right), general disorganization, compromised sterile packaging, storage of supplies beyond manufacturing guidelines, and improper co-storage of long-term food and cleaning supplies in clinic storage areas.

Photo 12. Misaligned labels noting "Blade Drive Assembly" for a bin containing intermittent catheters. Photographed 1-5-2026.


Photo 13. Examination table missing disposable paper. Photographed 1-5-2026.

- Eight of 11 clinics ensured common areas and examination rooms were equipped with essential core medical equipment and supplies (MIT 5.108.2, 72.7%). In three clinics, we found one or more of the following deficiencies: staff did not consistently conduct daily performance checks of the automated external defibrillator (AED); the examination table was missing disposable paper (see Photo 13, left); and several clinic glucometer quality control logs were incomplete.

- Eight of 11 clinics ensured examination rooms allow for privacy and confidentiality when providing medical services (MIT 5.110.4, 72.7%). In three clinics, we found one or more of the following deficiencies: the examination rooms lacked adequate provisions for visual privacy (see Photos 14 and 15; below); and clinical staff left a computer screen unlocked, leaving the screen visible and easily accessible to unauthorized persons (see Photo 16; below).

Photo 14. Exam room lacked adequate visual privacy. Photographed 1-5-2026.

Photo 15. Exam room lacked adequate visual privacy. Photographed 1-6-2026.

Photo 16. Clinical staff left computer screen unlocked. Photographed 1-5-2026.

The following test(s) are not scored but are reported for informational purposes:

- Cleaning staff managed by California Correctional Training and Rehabilitation Authority (CALCTRA) formerly known as California Prison Industry Authority (CALPIA) and SVSP clinical staff did not express concerns regarding the maintenance of infection control and prevention within the clinical health care areas (MIT 5.101.1, N/A). The facility maintained a standardized cleaning process utilizing hospital-grade chemical disinfectants specifically intended for clinical environments.
- Clinical staff did not report any concerns regarding access to vital medical equipment or the availability of sufficient medical supplies (MIT 5.108.1, N/A). All essential equipment was found to be in proper working order, and the facility maintained an adequate inventory of clinical supplies to support patient care requirements without interruption.

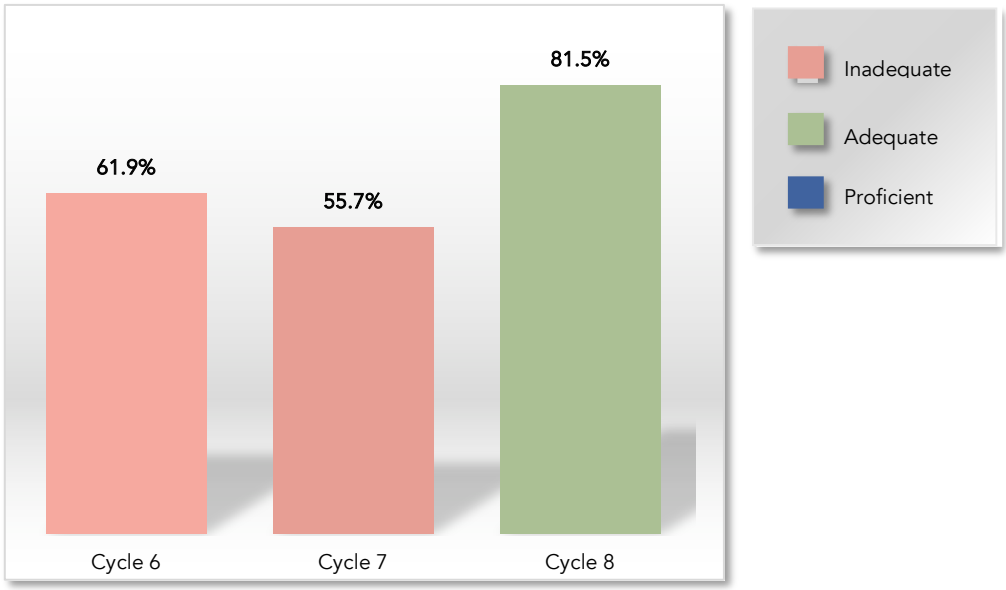
- We inspected indoor patient waiting areas. Health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 17; right). During our inspection, we did not observe overcrowding in any clinic indoor waiting areas.

Photo 17. Sufficient patient waiting area. Photographed 1-6-2026.

- At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999, N/A).

Analysis of Performance Across Inspection Cycles

Figure 5. Health Care Environment, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SVSP performed above established standards for health care environment, successfully meeting the requirements for this cycle. The institution exceeded the 75.0 percent compliance threshold for health care environment, reaching 81.5 percent in Cycle 8. This rating demonstrates significant improvement following previous inadequate ratings of 61.9 percent in Cycle 6 and 55.7 percent in Cycle 7.

Table 14. Health Care Environment Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For informational purposes only: Did the clinical health care staff report any concerns with maintaining infection control? (5.101.1)	0	0	11	N/A
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101.2)	10	1	0	90.9%
Infection control: Are clinical health care areas completing and maintaining cleaning logs for all clinical areas and implementing cleaning protocols during modified programming? (5.101.3)	11	0	0	100%
Infection control: Do clinical health care areas ensure that reusable invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.1)	0	1	10	0
Infection control: Do clinical health care areas ensure that reusable non-invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.2)	6	0	5	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	10	1	0	90.9%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	3	5	50.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	11	0	0	100%
Warehouse, Conex, and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	5	6	0	45.5%
For informational purposes only: Did clinical health care staff report concerns with access to all vital and properly working medical equipment and sufficient medical supplies? (5.108.1)	0	0	11	N/A
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108.2)	8	3	0	72.7%
Clinical areas: Are the environments in the common clinical areas conducive to providing medical services? (5.109.1)	11	0	0	100%
Clinical areas: Are the environments in the common non-clinical areas conducive to providing medical services? (5.109.2)	11	0	0	100%
Clinical areas: Do the clinic exam rooms have adequate space to provide medical services? (5.110.1)	11	0	0	100%
Clinical areas: Are the clinic exam rooms free of clutter and conducive to providing medical services? (5.110.2)	11	0	0	100%
Clinical areas: Do clinic exam rooms have working computer stations and well-maintained furniture and accessible medical equipment? (5.110.3)	9	2	0	81.8%
Clinical areas: Do clinic exam rooms allow for privacy and confidentiality when providing medical services? (5.110.4)	8	3	0	72.7%
For informational purposes only: 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 test is not scored. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **81.5%**

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

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

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 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. 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.

Transfers: Case Review Ratings and Results Summary

In this cycle, case review found SVSP performed well in the transfer process in assessments, interventions, and medication continuity when patients transferred into the institution and returned from hospitalization. Our clinicians identified opportunities for improvement in notification of the pending specialty appointments when patients transferred out of the institution. Considering all factors, the OIG rated the case review component of this indicator ***proficient***.

Case Review Results

Table 15. Case Review Transfers Results

Transfer events*	Deficiencies†	Significant deficiencies‡
67	18	1

* The OIG clinicians reviewed 67 events in 18 cases in which patients transferred into or out of the institution and 33 events in which patients returned from an off-site hospital or emergency room.

† Deficiencies occurred in cases 1, 2, 9, 10, 23, 26, 28–31, and 33.

‡ A significant deficiency occurred in case 30.

Performed Well

OIG clinicians found SVSP performed well in the following areas:

- Transfers In[45]
- Hospital Returns[46]

Performed Satisfactorily with Opportunities for Improvement

OIG clinicians found SVSP performed satisfactorily with opportunities for improvement in the following areas:

- Transfers Out[47]

  OIG clinicians found nurses screened patients appropriately and ensured all patients transferred with their medical equipment. However, our clinicians identified a pattern of deficiencies for incomplete transfer screening information, as follows:

  - In cases 2, 30, and 31, the nurses did not notify the receiving institution of pertinent patient hand off communication for routine pending specialty appointments and wound care orders.

Performed Poorly, Improvement Needed

OIG clinicians found no areas in this indicator in which SVSP performed poorly.

[45] Transfer-in deficiencies occurred in cases 9, 26, and 28, none of which were significant.

[46] Hospital-returns deficiencies occurred in cases 1, 9, 10, 23, and 33, none of which were significant.

[47] Transfer-out deficiencies occurred in cases 2, 29, 30, and 31. A significant deficiency occurred in case 30.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians interviewed the receiving and release (R&R) RN. The RN was knowledgeable about the transfer process. The RN reported transfer-out packets are prepared by the night shift RN. However, on the day of the patient's departure, the RN will review the patient's electronic health record for any updates regarding appointments or medications prior to the patient transferring out of the institution.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure nurses document pending specialty referrals for patients transferring to other institutions and should implement and monitor remedial measures as appropriate.

Transfers: Compliance Ratings and Results Summary

Compliance Rating
ADEQUATE
Compliance Score
(82.8%)

SVSP demonstrated an acceptable performance for this indicator. Based on the overall compliance score result of 82.8 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- Nursing staff demonstrated proficiency in completing initial health screenings and answering all screening questions within the required time frame for 24 of 25 patients (MIT 6.001, 96.0%). For one patient, nursing staff did not document the patient's weight in the initial health screening form.
- Nursing staff showed proficiency in completing the assessment and disposition sections of the initial health screening form for all 24 applicable sampled patients (MIT 6.002, 100%).

SVSP performed in the ***inadequate*** range in the following sub-indicators:

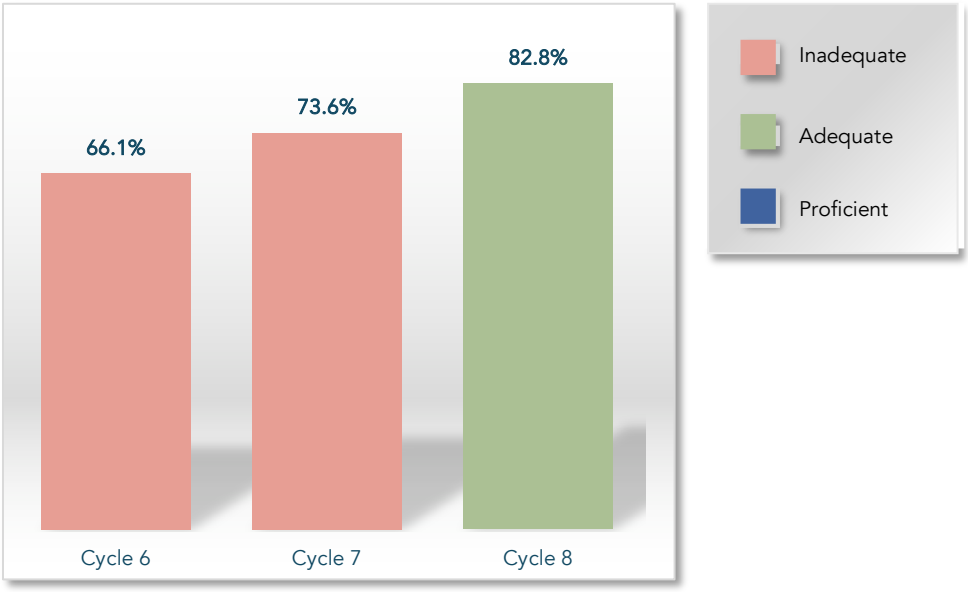
- Nursing staff ensured medications were administered or delivered without interruption for 11 of 21 applicable sampled patients (MIT 6.003, 52.4%). For 10 patients, we found one or more of the following deficiencies: incomplete documentation of the patient's reason for refusing medication or reason for not presenting to the medication line; and no evidence showing whether the patient refused or received medication.

Compliance On-site Inspection and Discussion:

- During the week of the on-site inspection, SVSP had no patients transferring out who met the required criteria for testing medications ordered or durable medical equipment (MIT 6.101, N/A).

Analysis of Performance Across Inspection Cycles

Figure 6. Transfers, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SVSP performed above established standards for **Transfers**, successfully meeting the requirements for this cycle The institution exceeded the 75.0 percent compliance threshold for the **Transfers** indicator, reaching 82.8 percent in Cycle 8. SVSP's performance in this cycle demonstrates significant improvement, following prior improvement from 66.1 percent in Cycle 6 to 73.6 percent in Cycle 7, and is now well into the adequate range, nearing proficiency.

Table 16. Transfers Compliance Test Scores

Compliance Questions	Scored Answers			
	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)	24	1	0	96.0%
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	0	1	100%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or issued without interruption? (6.003)	11	10	4	52.4%
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): **82.8%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- Nursing leadership should develop strategies to ensure nurses administer medications without interruption to newly arrived patients. Leadership should implement and monitor 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.

Medication Management: Case Review Ratings and Results Summary

In this cycle, case review found SVSP performed well in medication management. SVSP frequently ensured patients timely received newly prescribed medications, hospital discharge medications, specialized housing medications, and transfer medications. However, we identified opportunities for improvement in which nursing staff did not always administer chronic care medications timely or notify a provider with abnormal blood sugar results. Considering all factors, the OIG rated the case review component of this indicator ***proficient***.

Case Review Results

Table 17. Case Review Medication Management results

Medication Events*	Deficiencies†	Significant Deficiencies‡
130	17	7

* The OIG clinicians reviewed 130 events in 28 cases related to medications and found 17 medication deficiencies, seven of which were significant. Medication events occurred in cases 1, 2, 8, 9–27, 29–33, and 49.

† Medication deficiencies occurred in cases 1, 2, 10, 11, 13, 14, 16, 19–21, 24, 29, and 33.

‡ Significant deficiencies occurred cases 10, 14, 24, and 33.

Performed Well

OIG clinicians found SVSP performed well in the following areas:

- Newly Prescribed Medications[48]
- Hospital Discharge Medications[49]
- Specialized Medical Housing Medications[50]
- Transfer Medications[51]

Performed Satisfactorily with Opportunities for Improvement

Our clinicians found SVSP performed satisfactorily with opportunities for improvement in the following area:

- Chronic Care Medication[52]

  OIG clinicians found nurses generally administered chronic care medications timely. However, we found opportunities for improvement in the following cases:

  - In case 10, in January, February, and April 2025, the nursing staff did not always notify the RN or provider of abnormal blood sugar readings for this diabetic patient. A similar finding occurred in case 33 for a patient in the specialized medical housing unit.

  - In case 14, on one day the patient did not receive medication to treat blood clots and seizures.

Performed Poorly, Improvement Needed

OIG clinicians found no areas in this indicator in which SVSP performed poorly.

[48] Newly prescribed medication deficiencies occurred in case 13 and 24. A significant deficiency occurred in case 24.

[49] Hospital discharge medications did not have any deficiencies.

[50] A specialized medical housing deficiency occurred in case 33, which was significant

[51] A transfer medication deficiency occurred in case 29. We found no significant deficiencies.

[52] Chronic care medication deficiencies occurred in cases 1, 10, 11, 13, 14, 16, and 19–21. Significant deficiencies occurred in cases 10 and 14.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians inspected the medication administration areas in B Yard and C Yard. They observed medication preparation areas and interviewed LVNs in the medication administration areas. The LVNs reported they usually do not attend the morning huddle because medication pass occurs at the same time. However, they stated they would contact the provider if they had any medication concerns or issues. In B yard, two LVNs conduct medication administration on the morning shift, and one handles the evening shift. C yard similarly staffed two medication administration LVNs in the morning shift but staffed two again on the evening shift.

Photo 18. Pharmacy work room. Photographed 2-19-26.

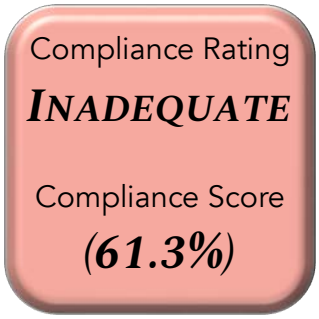
During the on-site inspection, patients in C yard had restricted movement. As a result, LVNs administered medications directly in the housing units instead of in the clinic. Nurses pushed the medication cart to each housing unit and completed medication administration four times per day.

Nursing leadership reported, during the on-site inspection, SVSP self-identified processes to improve narcotics accountability and LVN documentation in the MAR for patients who refused to come to the medication window. Additionally, SVSP now requires nurses to clearly include the reason in the MAR when they document "no show/no barrier" as the reason for not administering a patient's medications.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

Medication Management: Compliance Ratings and Results Summary



SVSP presents substantial opportunities for improvement in this indicator. Based on the overall compliance score result of 61.3 percent, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- The institution showed proficiency in making newly ordered prescription medications and hospital discharge medications available to patients within the required time frames for all sampled patients (MIT 7.002.1, 100% and MIT 7.003.1, 95.8%). For one patient, the provider did not order the hospital discharge medications within the required time frame.
- The institution appropriately stored and secured narcotic medications in all 11 applicable clinic and medication line locations (MIT 7.101, 100%).
- Staff successfully stored valid, unexpired medications in all 12 medication line locations (MIT 7.104 100%).
- SVSP followed general security, organization, and cleanliness management protocols in its main and remote pharmacies (MIT 7.108, 100%).
- The institution properly stored refrigerated or frozen medications in its main and remote pharmacies (MIT 7.110, 100%).

SVSP performed in the ***inadequate*** range in the following sub-indicators:

- Only six of 20 applicable patient samples received chronic care medications within required time frames (MIT 7.001, 30.0%). In 14 patient samples, we found one or more of the following deficiencies: incomplete documentation of the patient's reason for refusing medication or reason for not presenting to the medication line; chronic care medications were not timely made available to the patients; and KOP medications were not issued within policy time frames.
- The institution administered or issued newly ordered prescription medications within required time frames for 15 of 25 patients (MIT 7.002.2, 60.0%). For 10 patients, we found one or more of the following deficiencies: nursing staff did not administer direct

observation therapy (DOT) medication according to the provider's order; incomplete documentation of the patient's reason for refusing medication or reason for not presenting to the medication line; and KOP medications were not issued within the policy time frame.

- The institution's pharmacy made available post-hospitalization medication orders within the required time frame for only nine of 22 applicable sampled patients (MIT 7.003.2, 40.9%). For 13 patients, we found one or more of the following deficiencies: medications were not timely made available; and the pharmacy was not timely in filling and dispensing medications as ordered.
- The institution administered or issued post-hospitalization medication orders within the required time frames for nine of 24 applicable sampled patients (MIT 7.003.3, 37.5%). In 15 patients, we found one or more of the following deficiencies: no evidence showing whether the patient refused or received medication; incomplete documentation of the patient's reason for refusing medication; nursing staff failed to deliver medication to the patient by the ordering provider's administration date; and KOP medications were not issued within policy time frames.
- The institution administered or delivered medications without interruption to patients transferring within the institution for 11 of 25 patients (MIT 7.005, 44.0%). For 14 patients, we found one or more of the following deficiencies: incomplete documentation of the patient's reason for refusing medication or reason for not presenting to the medication line; and no evidence showing whether the patient refused or received medication.
- The institution administered or delivered medications without interruption to patients laying over at SVSP for six of 10 sampled patients (MIT 7.006, 60.0%). For four patients, we found incomplete documentation of the patient's reason for refusing medication.
- SVSP appropriately stored and secured non-narcotic medications in only six of 12 clinic and medication line locations (MIT 7.102, 50.0%). In six locations, we found one or more of the following deficiencies: medication storage area was unsanitary; the medication area lacked a clearly labeled designated area for refrigerated medications to be returned to the pharmacy; and nurses did not maintain unissued medication in its original labeled packing (see Photo 19; right).

Photo 19. Nurses did not maintain unissued medication in its original labeled packing. Photographed 1-5-2026.

- Staff kept medications protected from physical, chemical, and temperature contamination in four of 12 clinic and medication line locations (MIT 7.103, 33.3%). In eight locations, we found one or more of the following deficiencies: several medication refrigerators were unsanitary (see Photo 20; below); staff did not consistently record the room temperature; and external and internal medications were not stored separately.

Photo 20. Unsanitary medication refrigerator. Photographed 1-6-2026.

- Nurses exercised proper hand hygiene and contamination control protocols in four of six applicable locations (MIT 7.105, 66.7%). In two locations, some nurses neglected to wash or sanitize hands when required. These occurrences included before preparing and administering medications, or before each subsequent re-gloving.
- Staff in two of three applicable medication preparation and administration areas showed appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 66.7%). In one location, staff failed to demonstrate the appropriate process to reconcile new medication orders. Of note, during the on-site inspection, a majority of the nursing staff administering the medications were employed as contractors. Therefore, OIG took exemption in interviewing and observing medication administration processes performed by non-regular nursing registry staff.

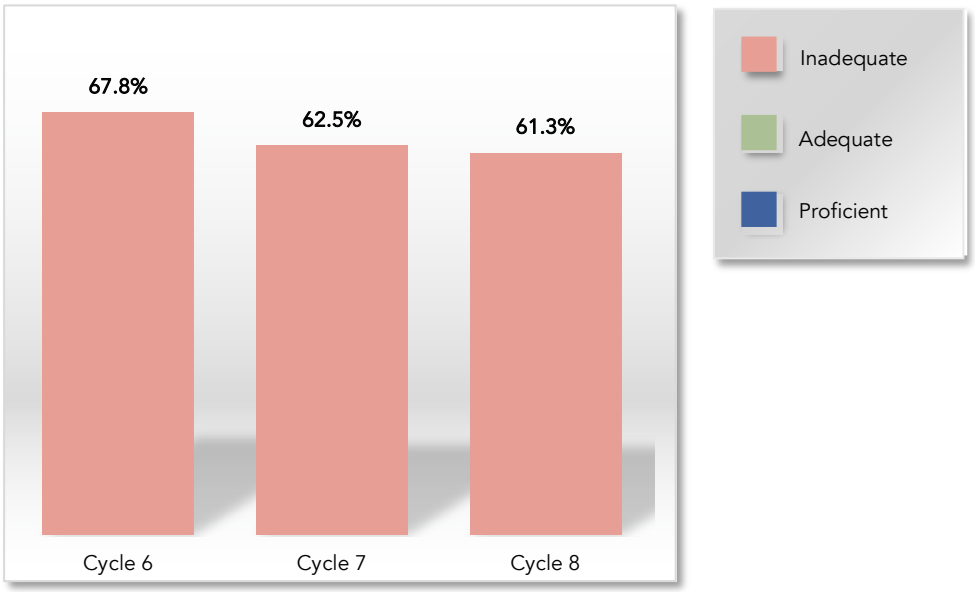
- Staff in three of five applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 60.0%). In two locations, we found one or more of the following deficiencies: we observed a medication nurse who did not always ensure patients swallowed DOT medications; and medication administration occurred outside of the distribution time frame in one yard.
- SVSP properly stored nonrefrigerated medication in one of two pharmacy location (MIT 7.109, 50.0%). In one location, we found staff beverages kept in the medication storage area.
- The pharmacist-in-charge (PIC) did not properly account for narcotic medications stored in the main pharmacy (MIT 7.111, zero). Specifically, pharmacy staff did not appropriately complete the medication storage area inspection checklist (CDCR 7477-B) or the automated drug delivery system medication storage inspection checklist (CDCR 7477-C).
- We examined 25 medication error reports. For 17 reports, the PIC did not initiate the medication follow-up report timely (MIT 7.112, 32.0%).

The following test(s) are not scored, but are reported for informational purposes:

- 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 SVSP, the OIG did not find any applicable medication errors (MIT 7.998, N/A).
- The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. All 10 applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999, N/A).

Analysis of Performance Across Inspection Cycles

Figure 7. Medication Management, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SVSP performed below established standards for **Medication Management**, highlighting significant opportunities for improvement. The institution did not meet the 75.0 percent compliance threshold for **Medication Management**, attaining only 61.3 percent in Cycle 8. This follows a downward trend from 67.8 percent in Cycle 6 and 62.5 percent in Cycle 7, indicating performance in this indicator continues to regress.

Table 18. Medication Management Compliance Test Scores

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)	6	14	5	30.0%
Did health care staff make available, new order prescription medications to the patient within the required time frames? (7.002.1)	6	0	19	100%
Did health care staff administer or issued new order prescription medications to the patient within the required time frames? (7.002.2)	15	10	0	60.0%
Upon the patient's discharge from a community hospital: Did the provider order the medications within required time frames? (7.003.1)	23	1	1	95.8%
Upon the patient's discharge from a community hospital: Were all ordered medications made available to the patient within required time frames? (7.003.2)	9	13	3	40.9%
Upon the patient's discharge from a community hospital: Were all ordered medications administer or issued to the patient within required time frames? (7.003.3)	9	15	1	37.5%
For patients received from a county jail: Did the provider order the medications within required time frames? (7.004.1)	N/A	N/A	N/A	N/A
For patients received from a county jail: Were all medications made available to the patient within the required time frames? (7.004.2)	N/A	N/A	N/A	N/A
For patients received from a county jail: Were all ordered medications administer or issued to the patient within required time frames? (7.004.3)	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)	11	14	0	44.0%
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)	11	0	1	100%
All clinical and medication line storage areas for non-narcotic medications: Does the institution properly secure and store non-narcotic medications in the assigned storage areas? (7.102)	6	6	0	50.0%
All clinical and medication line storage areas for non-narcotic medications: Does the institution keep non-narcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	4	8	0	33.3%
All clinical and medication line storage areas for non-narcotic medications: Does the institution safely store non-narcotic medications that have yet to expire in the assigned storage areas? (7.104)	12	0	0	100%
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)	4	2	6	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	2	1	9	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	3	2	7	60.0%
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 non-refrigerated medications? (7.109)	1	1	0	50.0%

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)	0	1	1	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	8	17	0	32.0%
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 test is not scored. Please see the indicator for discussion of this test.			
For Information Purposes Only: Pharmacy: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This test is not scored. Please see the indicator for discussion of this test.			
Overall percentage (MIT 7): **61.3%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- Health care leadership should develop, implement, and monitor strategies to ensure staff timely make available and administer medications to patients as well as accurately document the medication administration record (MAR) summaries, as described in CCHCS policy and procedures.

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.

Preventive Services: Compliance Ratings and Results Summary

SVSP performed well, achieving a proficient compliance rating in this indicator. Based on the overall compliance score result of 86.1 percent, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- The institution demonstrated proficiency in screening patients for tuberculosis (TB) for all 25 patients (MIT 9.003, 100%).
- The institution demonstrated proficiency in offering influenza during the most recent completed influenza season for 24 of 25 patients (MIT 9.004, 96.0%). For one patient, the record contained no evidence of a signed refusal form in the patient's medical record.
- The institution demonstrated proficiency in offering colorectal cancer screening to 23 of 25 patients (MIT 9.005, 92.0%). For two patients, the record contained no evidence indicating either that the patient was offered, completed, or refused a fecal immunochemical test (FIT) in the last 12 months or the patient had a normal colonoscopy record in the last 10 years.

SVSP performed in the ***adequate*** range in the following sub-indicators:

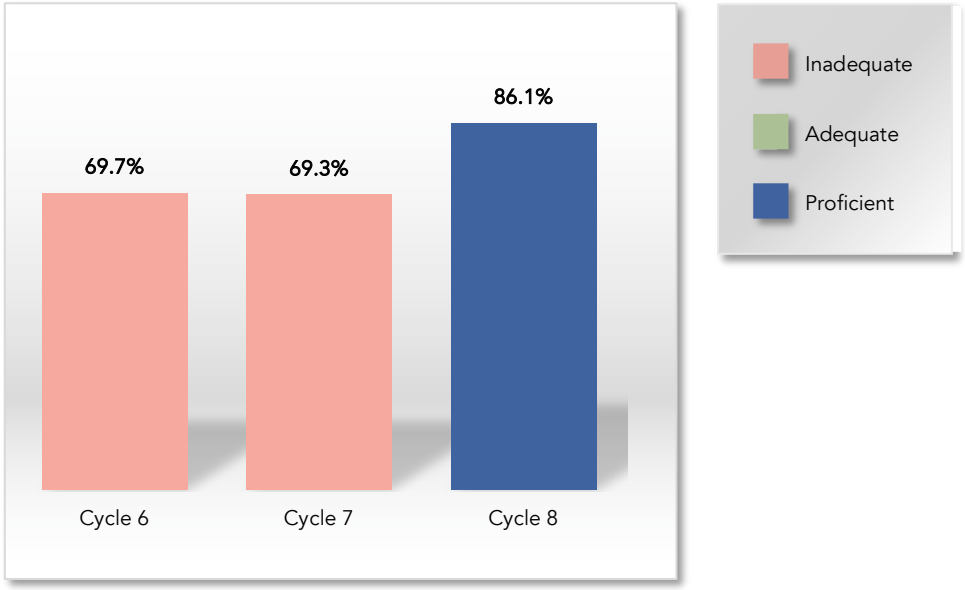
- The institution achieved a good compliance score in administering TB medications for five of six sampled patients (MIT 9.001, 83.3%). For one patient, nursing staff did not document the patient's reason for refusing TB medication.
- The institution achieved sufficient performance in offering immunizations to chronic care patients for 11 of 14 sampled patients (MIT 9.008, 78.6%). For three patients, the record contained no evidence showing whether chronic care patients received or refused their pneumococcal vaccinations.

SVSP performed in the ***inadequate*** range in the following sub-indicators:

- The institution monitored patients taking TB medications during the treatment period for four of six sampled patients (MIT 9.002, 66.7%). For two patients, medical staff did not document and address the required clinical symptoms and potential adverse drug reactions in the TB screening Evaluation Report.

Analysis of Performance Across Inspection Cycles

Figure 8. Preventative Services, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SVSP performed above established standards for preventive services, successfully meeting the requirements for this cycle. The institution exceeded the 75.0 percent compliance threshold for preventive services, reaching a now proficient score of 86.1 percent in Cycle 8. This rating demonstrates significantly improved performance in this indicator from 69.7 percent in Cycle 6 and 69.3 percent in Cycle 7.

Table 19. Preventive Services Compliance Test Scores

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	5	1	0	83.3%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent 90-day period they were on the medication? (9.002)	4	2	0	66.7%
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)	23	2	0	92.0%
Female patients from the age of 40 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)	11	3	11	78.6%
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): **86.1%**

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- Health care leadership should determine the root cause(s) for challenges to timely monitoring patients taking TB medications and should implement and monitor appropriate remedial measures.

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). Our clinicians 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. For some of these areas, we discuss specific nursing performance issues in their related indicators. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing nursing performance, our clinicians understand 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**.

Nursing Performance: Case Review Ratings and Results Summary

In Cycle 8, OIG clinicians found SVSP nursing staff performed well in the transfer-in process, hospital return process, medication management, and correctly identified urgent sick call requests that required a same-day nursing assessment. However, we found opportunities for improvement in outpatient nursing assessments, interventions, documentation, transfer-out, specialty services, and specialized medical housing. Additionally, OIG clinicians identified nurses needed significant improvement in wound care and emergency care. Considering all factors, the OIG rated this indicator ***adequate***.

Case Review Results

Table 20. Case Review Nursing Performance Results

Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
275	102	19

* We reviewed 275 nursing encounters in 42 cases. Of the nursing encounters we reviewed, 78 were in the outpatient setting.

† Deficiencies occurred in cases 1–5, 8–11, 19, 20, 22, 23, 26, 28, 30–33, 36, 39, 42, 43, 45, and 49.

‡ Significant deficiencies occurred in cases 1, 2, 5, 9, 10, 20, 22, 30, and 49.

Table 21. Case Review Outpatient Nursing Performance Results

Outpatient Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
78	35	11

* Nursing outpatient encounters occurred in cases 1, 2, 8–11, 13, 18–20, 22, 23, 25, and 35–48. In the total number of nursing outpatient events, 49 were sick call events.

† The outpatient nursing performance deficiencies occurred in cases 2, 9–11, 20, 22, 23, 36, 39, 42, 43, and 45.

‡ Significant deficiencies occurred in cases 9, 10, and 20.

Performed well

OIG clinicians found SVSP nurses performed well in the following areas:

- Hospital Returns[53]

  OIG clinicians found nurses frequently performed appropriate assessments and contacted providers promptly. Please refer to the **Transfers** indicator for further details.

- Transfer-in[54]

  Nursing staff performed well in assessments, interventions, and medication continuity when patients transferred into the institution. Our clinicians found no significant deficiencies and no patterns of deficiencies for nurses handling patients transferring into the institution. Please refer to the **Transfers** indicator for further details.

[53] Hospital return nursing performance deficiencies occurred in cases 1, 9, 10, and 33, none of which were significant.

[54] Transfer-in nursing performance deficiencies occurred in cases 9, 26, and 28, none of which were significant.

- Medication Management

  SVSP nurses generally administered medications as ordered, and patients frequently received their KOP medications without delay. Please refer to the **Medication Management** indicator for further details.

Performed Satisfactorily with Opportunities for Improvement

OIG clinicians found SVSP nurses performed satisfactorily with opportunities for improvement in the following areas:

- Outpatient Nursing Assessment, Interventions, and Documentation

  Nurses generally performed adequate assessments, interventions, and documentation. Additionally, nurses almost always triaged sick call requests timely and assessed patients timely.[55] However, we found opportunities for improvement in the following cases:

  - In case 10, the patient was evaluated at the hospital and had an incision & drainage to the wound on the left arm.[56] The RN triaged the sick call slip the day after the patient returned from the hospital, and the patient requested a dressing change to the left arm. The nurse inappropriately scheduled the patient to be seen within one business day instead of assessing the patient on the same day.

  - In case 11, an RN assessed the patient for a sick call complaint of chronic lower back pain and leg pain. The RN did not subjectively assess KOP medication compliance, perform a back joint inspection and assessment, or perform a range of motion.[57]

  - In case 20, the RN assessed the patient for a follow-up appointment after the patient was evaluated in the TTA and had received a breathing treatment for shortness of breath and wheezing. At the RN follow-up appointment, the nurse documented the patient had wheezing but no shortness of breath. However, the nurse did not inform the provider of the wheezing for further plan of care. Additionally, the RN did not assess a full set of vital signs to include the heart rate, temperature, and oxygen saturation.

[55] In the outpatient setting, our clinicians reviewed 49 sick call events and identified 22 deficiencies, two of which were significant. The sick call deficiencies occurred in cases 2, 9–11, 20, 22, 23, 36, 39, 42, 43, and 45. Significant deficiencies occurred in case 20.

[56] Incision & drainage is a minor surgical procedure used to treat abscesses, boils, or infected cysts by cutting into the skin and allowing fluid to drain.

[57] KOP means "keep-on-person" and refers to medications a patient can keep and self-administer according to the directions provided.

SVSP nurses performed sufficiently with completing accurate documentation. However, OIG clinicians identified 14 documentation deficiencies, none of which were significant.[58] The following is an example.

  - In case 42, the sick call nurse evaluated the patient with a complaint of toenail fungus. The nurse documented a follow-up appointment was required; however, the order was not initiated. Furthermore, the nurse did not specify with whom the follow-up needed to occur.

- Care Coordinators and Care Managers

  OIG clinicians reviewed four cases in which a care coordinator or care manager assessed the patients, and we identified five deficiencies, four of which were significant.[59] All the deficiencies occurred in one case. The following is an example:

  - In case 10, for the months of April, May, and June 2025, the patient intermittently attended weekly diabetic care management visits. The OIG clinicians identified a pattern in which nurses did not document reviewing the abnormal blood sugar trends, did not assess the patient, and did not provide interventions when warranted, including notifying the provider of abnormal findings. Additionally, nurses did not always document vital signs during these encounters.

- Transfer-Out[60]

  OIG clinicians found nurses performed satisfactorily in the transfer-out process. Our clinicians identified opportunities for improvement in notification of the pending specialty appointments when patients transferred out of the institution. Please refer to the **Transfers** indicator for further details.

- Specialized Medical Housing

  SVSP nurses provided sufficient care in the correctional treatment center (CTC). Nurses generally performed good assessments and interventions; however, we identified opportunities for improvement in nursing performance in the specialized medical housing setting. Please refer to the **Specialized Medical Housing** indicator for further details.

[58] Nursing documentation deficiencies occurred in cases 2, 9–11, 20, 22, 23, 36, 39, 42, 43, and 45.

[59] Care coordination and care manager events occurred in cases 2, 9, 10, and 18. All deficiencies occurred in case 10.

[60] Transfer-out nursing performance deficiencies occurred in cases 2, 30, and 31. A significant deficiency occurred in case 30.

- Specialty Services

  Nurses generally performed appropriate assessments, interventions, and documentation for patients returning from off-site specialty service appointments; however, we identified opportunities for nursing improvement related to specialty services. Please refer to the **Specialty Services** indicator for further details.

Performed Poorly, Improvement Needed

OIG clinicians found SVSP nurses performed poorly in the following areas:

- Wound Care

  We reviewed three cases in which nurses provided wound care to patients, and we identified four deficiencies, two of which were significant.[61] Nurses performed incomplete assessments and poor documentation of wounds. The following are significant deficiencies:

  - In case 9, nurses frequently performed daily wound care to the right elbow for the month of June. Nurses documented the patient had necrotic tissue but did not document the color of wound drainage and did not notify the physician of the abnormal findings.[62] Additionally, the nurses inconsistently documented the number of wounds to the right elbow, and the LVN did not notify an RN or physician regarding abnormal wound findings. Lastly, an RN did not perform a final wound assessment to determine whether the wound was healed.

  - In case 10, the patient had an order to start daily wound care dressing changes to the left arm for eight days. However, nursing staff did not perform the wound dressing change on multiple days. Additionally, the patient was seen in the RN clinic for a dressing change, and the nurse documented two new wound areas to the left arm. However, the nurse did not assess vital signs, assess the new wound areas to include measurements, redness, and pain level during the encounter.

- Emergency Services

  OIG clinicians found SVSP nurses needed significant improvement in nursing assessments, interventions, and documentation during emergency events. Please refer to the **Emergency Services** indicator for further details.

[61] Wound care events occurred in cases 2, 9, and 10. Deficiencies occurred in cases 2, 9, and 10. Significant deficiencies occurred in cases 9 and 10.

[62] Necrotic tissue is dead, non-viable tissue resulting from cell death caused by infection, toxins, or trauma.

Clinician On-Site Inspection

During the on-site inspection, the OIG clinicians interviewed nursing staff in the outpatient clinics in C and B yards, medication areas, telemedicine, triage and treatment area (TTA), CTC, and the receiving and release (R&R) areas. We attended organized huddles with the care teams.

Photo 21. B yard clinic examination room. Photographed 2-20-26.

At the on-site inspection, C yard had restricted patient movement, and all patients were escorted by custody staff for healthcare appointments. SVSP reported nursing had a backlog of 10 RN appointments and seven LVN appointments. The RN reported, due to the challenges with the restricted patient movement, RNs extended their work day to accommodate all scheduled patients for that day.

During our on-site inspection, we met with the chief nurse executive (CNE), outpatient director of nursing (DON), and the inpatient DON, who was acting in this role during this time. Nursing leadership discussed improvement plans for completing emergency response checklists, documenting medication administration for patients who do not arrive to pick up their medications and completing the scheduled RN sick call face-to-face assessments each day as scheduled, even with the restricted patient movement. Nursing leadership reported challenges with several nursing staff and supervisors being on long term leave. Registry nursing staff was utilized to fill shifts, but using registry staff was challenging because these staff only receive one week of training, which is the standard training by CCHCS.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure nurses thoroughly document wound care assessments, including clinical appearance of the wound, surrounding tissue, and measurements. Leadership should implement and monitor remedial measures as appropriate.

Provider Performance

In this indicator, OIG 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 also examined provider performance across several clinical settings and programs, including emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. The OIG assessed provider care through case review only and performed no compliance testing for this indicator.

Provider Performance: Case Review Ratings and Results Summary

Case review found SVSP providers delivered good care for the patients, as with the previous cycle. Providers generally made appropriate evaluations, diagnosed medical conditions correctly, and managed chronic conditions effectively. They referred patients to specialists and for higher level of care when medically indicated. However, the providers inconsistently completed clinical documentations for on-call shifts and nursing co-consultations, and only occasionally sent complete patient test result notification letters. After careful consideration of all provider performance factors, the OIG rated this indicator ***adequate***.

Case Review Results

Table 22. Case Review Provider Performance Results

Provider Encounters*	Deficiencies†	Significant Deficiencies‡
148	58	15

*OIG reviewed 148 providers encounters.

† Deficiencies occurred in cases 1, 2, 9, 11, 13–25, 33, and 49.

‡ Significant deficiencies occurred in cases 9, 13–15, 20, 22–24, and 33.

Table 23. Provider Performance Detailed Cases Results

Total Detailed Cases Reviewed	Proficient	Adequate	Inadequate
20	0	18	2

Performed Well

OIG clinicians found SVSP providers performed well in the following areas:

- Provider Continuity[63]
- Specialty Services[64]

Performed Satisfactorily with opportunities for improvement

OIG clinicians found SVSP providers performed satisfactorily with opportunities for improvement in the following areas:

- Outpatient Assessment and Decision-Making

  Providers generally made appropriate assessments and sound medical decisions for their patients. Most of the time, providers diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to specialists when medically indicated. However, OIG clinicians identified 14 deficiencies related to poor medical assessments and decision-making, two of which were significant.[65] The following is an example:

  - In case 13, the provider evaluated the patient for breast enlargement; however, the provider did not examine the patient's breasts.

- Emergency Care

  Providers managed patients in the TTA with urgent or emergent conditions appropriately and were available for consultations with TTA staff. However, the providers sometimes did not document progress notes in the EHRS. OIG clinicians identified 20 deficiencies related to documenting progress notes when consulting with nursing staff in the TTA, one of which was significant.[66] We discuss these deficiencies further in the **Emergency Care** indicator. The following is an example:

  - In case 20, the patient went to the TTA for difficulty urinating, and the TTA nurse notified the provider. However, the provider did not document a progress note for this event.

[63] OIG clinicians identified no deficiencies in this sub-indicator.

[64] OIG clinicians identified two minor deficiencies in cases 17 and 25.

[65] Deficiencies occurred in cases 9, 11, 13, 14, 20, 22, 23, and 49. Significant deficiencies occurred in cases 9 and 13.

[66] Deficiencies occurred in cases 1, 9, 16, 18, 19, 20, 21, 22, 23, and 25. A significant deficiency occurred in case 20.

- Review of Records

  Providers generally reviewed the health records for provider-patient encounters. Providers focused on any new laboratory results, encounters with specialists, hospitalization reconciliations, and medications that were new or needed renewing. However, the OIG clinicians identified three significant deficiencies related to review of hospital records and one minor deficiency related to review of an x-ray report.[67] The following is an example:

  - In case 22, the provider reviewed the hospital discharge summary for the patient with syncope and pulmonary embolism.[68] The hospitalist recommended the patient should follow up with a hematology specialist concerning the duration of treatment with a blood thinning medication. However, the provider did not refer the patient to a specialist and did not document a rationale for not referring the patient. Furthermore, the provider did not order a low bunk chrono for the patient taking a blood thinning medication and with a history of fall and syncope.[69]

- Specialized Medical Housing

  Providers evaluated the patients in correctional treatment center (CTC) timely and appropriately. However, OIG clinicians identified six deficiencies, two of which were significant. We discuss these deficiencies further in the **Specialized Medical Housing** indicator.[70] The following is an example:

  - In case 33, the provider evaluated the patient and "noted distended" ascites during the CTC rounds but did not review the patient's vital signs.

Performed Poorly, Improvement Needed

OIG clinicians found SVSP performed poorly with improvement needed in the following areas:

- Chronic Care

  While providers generally managed patients' chronic health conditions, such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease, we

[67] Deficiencies occurred in cases 2, 22, and 23. Significant deficiencies occurred in cases 22 and 23.

[68] Syncope is a transient loss of consciousness, which can be caused by insufficient blood flow to the brain. A pulmonary embolism is a life-threatening condition caused by a blood clot blocking an artery in the lung and requires treatment with blood thinning medications.

[69] A low bunk chrono is an order for a patient to have a low positioned bed to prevent falls.

[70] Deficiencies occurred in cases 33 and 49. Two significant deficiencies occurred in case 33.

found important lapses in care. OIG clinicians identified six deficiencies, four of which were significant.[71] The following are examples:

- In case 24, the provider evaluated the patient with hypertension and documented an elevated blood pressure. The provider did not develop a plan to address the elevated blood pressure.

- In case 33, the provider evaluated the patient during an admission history and physical to the CTC. The provider documented: "Recent glucose 499 on 412, 543 on 9/17. On insulin glargine 6 units daily. Monitor, increase insulin glargine to 8 units, adjust as necessary." However, the provider did not order regular blood fingerstick tests to monitor the patient's elevated blood sugars.

- Documentation Quality

  Documentation is important because it shows the provider's thought process during clinical decision-making for all health care staff to access patient information to provide care timely. When contacted by nurses, providers often missed documenting the interactions. The OIG clinicians identified 29 deficiencies, four of which were significant.[72] The following are examples:

  - In case 9, the provider documented a TTA progress note 48 days after the encounter. Furthermore, the provider did not follow the "late entry" documentation procedure as per CCHCS policy.

  - In case 19, the TTA RN called the provider for consultation for the patient complaining of nausea and light headache. The provider ordered medication, Zofran, for nausea. After taking medication, the patient complained of trouble breathing. The nursing staff performed an EKG and orthostatic vitals, and the provider recommended to increase hydration and follow up on RN line in two days.[73] However, the provider did not document a progress note.

[71] Deficiencies occurred in cases 15, 17, 24, 33, and 49. Significant deficiencies occurred in cases 15, 24, and 33.

[72] Deficiencies occurred in cases 1, 2, 9, 16, 18, 19, 20, 21, 22, 23, 24, 25, and 49. Significant deficiencies occurred in cases 20, 23, and 24.

[73] An EKG is an electrocardiogram. This non-invasive test measures and records the electrical impulses from the heart and is used to help diagnose heart problems. Orthostatic vitals mean the blood pressure and pulse measurements are recorded in three separate positions: laying down, sitting, and standing.

- Patient Notification Letters

  Providers needed improvement in relaying diagnostic test result letters to their patients. Providers often sent incomplete patient test result notification letters or did not send them at all.[74] We further discuss these deficiencies in the **Diagnostic Services** indicator. The following are examples:

  - In case 14, the provider reviewed the test result for a blood level of a seizure medication. However, the test was not performed, and the provider erroneously sent the patient letter with the results as "within normal limits."
  - In case 18, the provider reviewed and signed the x-ray report. However, the provider did not create a patient result notification letter in EHRS.
  - In case 22, the provider endorsed the laboratory test results and created a patient result notification letter. However, the letter did not include whether the results were unchanged, or within normal limits, or as expected, or whether additional testing was required.

Clinician On-Site Inspection

OIG clinicians attended morning huddles led by clinic providers and observed good attendance and interactions by patient care team members. OIG clinicians interviewed medical leadership and providers during the on-site inspection. The clinic providers expressed good support by the medical leadership. Medical leadership stated they rely on many medical providers from the registry for staffing despite pay differential programs to attract providers, due to the high cost of

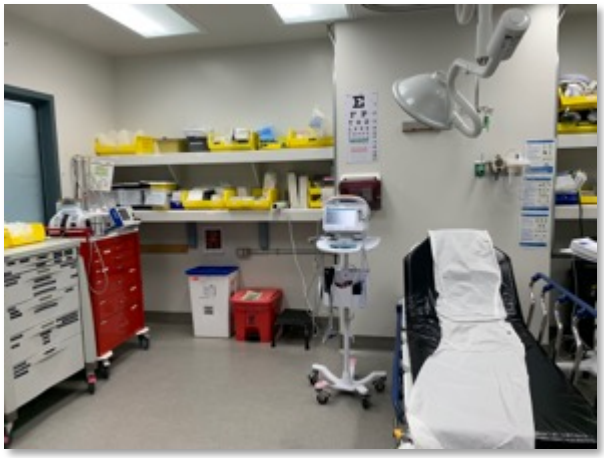


Photo 22. TTA treatment room.
Photographed 2-19-26.

Photo 23. Telemedicine equipment for providers.
Photographed 2-19-26.

[74] Deficiencies occurred in cases 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 22, 23, 32, and 33. A significant deficiency occurred in case 14.

living in the area and the high-risk populations in the institution. The medical leadership mentioned they initiated training providers on the clinical documentation expectations and started a quality improvement audit on the providers' on-call progress note documentations.

Case Review Recommendations

- Medical leadership should continue auditing and monitoring to ensure providers timely document appropriate progress notes for consultations with nursing staff during the clinic and on-call hours for clear communication and collaboration with the patient care team and continuity of patient care.
- Medical leadership should develop, implement, and monitor strategies to ensure providers document individual treatment goals and follow the patients' progress when managing chronic conditions such as hypertension and diabetes.

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, SVSP's specialized medical housing consisted of a correctional treatment center (CTC).

Specialized Medical Housing: Case Review Ratings and Results Summary

Case review found both SVSP providers and nurses provided sufficient care in the CTC. Nurses generally performed good assessments, frequently rounded on their patients, and usually provided good interventions. The institution also performed well in medication management. However, we did identify some opportunities for improvement in provider and nursing performance in the specialized medical housing setting. Considering all factors, the OIG rated this indicator ***adequate***.

Case Review Results

Table 24. Case Review Specialized Medical Housing Results

CTC events*	Deficiencies†	Significant deficiencies‡
45	15	4

* We reviewed four CTC cases that included 15 provider encounters and 14 nursing encounters. Due to the frequency of nursing and provider contacts in the specialized medical housing unit, we bundle up to two weeks of patient care into a single event.

† Deficiencies occurred in cases 32, 33, and 49.

‡ Significant deficiencies occurred in cases 33 and 49.

Performed Well

OIG clinicians found SVSP performed well in the following area:

- Medication Management[75]

Performed Satisfactorily with Opportunities for Improvement

Our clinicians found SVSP performed satisfactorily with opportunities for improvement in the following areas:

- Provider Performance

  Providers generally delivered good care in CTC. OIG clinicians found providers always completed history and physicals (H&Ps) timely and generally made appropriate assessment and decisions. However, we identified six deficiencies in managing patients' chronic medical conditions. One minor deficiency involved failure to document an interaction when contacted by a nurse, one minor deficiency related to not reviewing vital signs, and two minor deficiencies related to medical assessment and decision-making. The remaining two deficiencies were significant.[76] The following are examples:

  - In case 33, this patient underwent an ultrasound-guided paracentesis, and a provider ordered an oncology follow-up for liver cancer.[77] However, the provider did not ensure the patient had an order for the regular paracentesis to occur every two weeks.

  - In case 49, the provider evaluated the patient during an admission history and physical examination with documentation of high sugar readings. However, the provider did not order regular blood finger sticks to monitor the patient's blood sugars

- Nursing Performance[78]

  OIG clinicians found CTC nurses completed timely admission assessments, conducted rounds appropriately, and generally provided satisfactory care. However, we identified a pattern of deficiencies related to incomplete nursing assessments and documentation. The following are examples:

[75] Medication administration deficiencies occurred in cases 32, 33, and 49. Significant deficiencies occurred in cases 32 and 33.

[76] Deficiencies occurred in cases 33 and 49. The significant deficiencies occurred in case 33.

[77] Ultrasound-guided paracentesis is a medical procedure where a doctor puts a thin needle or small tube into the abdomen to remove fluid that has built up there.

[78] Nursing performance deficiencies occurred in cases 32, 33, and 49. A significant deficiency occurred in case 49.

- In case 33, this patient with a history of end stage liver disease had abdominal ascites and required a procedure to drain the fluid.[79] The nurses did not monitor the patient's weight, and they inconsistently documented the abdomen's appearance. Some nurses documented the abdomen was soft and others documented it was firm and distended.

- In case 49, the patient with a history of chronic kidney disease and hypertension complained of chest pains with radiation to the arm. However, the nurse did not immediately perform a physical assessment, instead delaying until one hour later when the patient complained again of chest pain.

Performed Poorly, Improvement Needed

OIG clinicians found no areas in this indicator in which SVSP performed poorly.

Clinician On-Site Inspection

Our clinicians toured the CTC and interviewed nursing staff. At the time of the on-site inspection, CTC housed medical and mental health patients. Twelve medical beds were occupied. The CTC had 24-hour nursing coverage, which included three RNs.

Photo 24. CTC negative pressure room. Photographed 2-20-26.

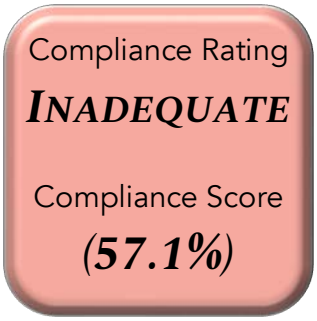
During business hours, the CTC had a designated provider, Monday through Friday, and nursing staff reported providers reconciled recommendations and placed appropriate orders for patients returning from specialist appointments and community hospitalizations. After hours, the nurses contacted the on-call provider to obtain verbal orders as needed.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

[79] Abdominal ascites is the abnormal accumulation of fluid in the space between the abdominal organs and the abdominal wall.

Specialized Medical Housing: Compliance Ratings and Results Summary



SVSP presents opportunities for improvement in this indicator. Based on the overall compliance score result of 57.1 percent, the OIG rated the compliance component of this indicator ***inadequate.***

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- Registered nurses demonstrated proficiency in completing an initial assessment of the patient at the time of admission for all six sampled patients (MIT 13.001, 100%).
- Providers exhibited proficiency in ordering medications within the required time frame upon the patient's admission for all six sampled patients (MIT 13.003.1, 100%).
- Health care staff exhibited proficiency in performing patient safety checks according to the institution's local operating procedure or within the required time frame (MIT 13.102, 100%).

SVSP performed in the ***inadequate*** range in the following sub-indicators:

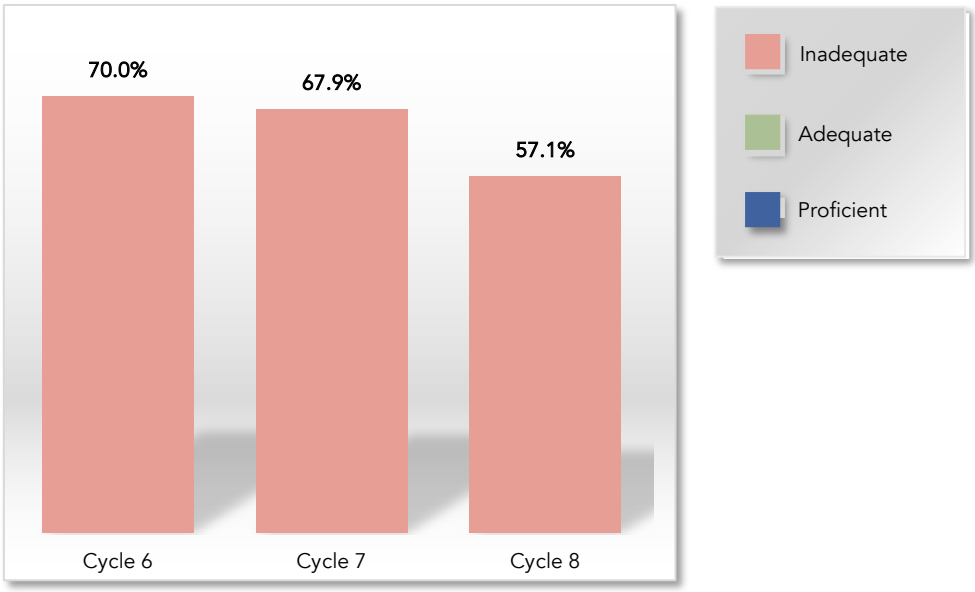
- Providers completed written history and physical examinations within the required time frame for four of six sampled patients (MIT 13.002, 66.7%). For two patients, providers were late in performing the history and physical examinations.
- Health care staff ensured all ordered medications were made available and administered to the patient within the required time frame for only one of six sampled patients (MIT 13.003.2, 16.7%, and MIT 13.003.3, 16.7%).
- Health care staff failed to maintain an operational call system and label patient rooms with broken call lights (MIT 13.101, zero). Specifically, When the OIG inspected the call light system in the Correctional Treatment Center (CTC), we learned, from both custody and nursing staff, the call system was operational for most CTC beds, but was not functioning correctly in cell 10 or 15. Specifically, the staff reported the call light located at the door above cell 10 was always on, but the system did not provide an audible and visible signal communication to nursing staff at the nursing station for either cell 10 or 15 to indicate the patient is calling for help, as required by California Code of

Regulations, title 22, section 79839.[80] For this reason, the staff explained they were conducting 15-minute rounding, per protocol for a non-functioning call light system, as they had no other method to determine whether these patients were requesting assistance. The staff provided copies of the logs showing the rounding for Cells 10 and 15 as evidence of complying with rounding protocols due to the non-functioning call system for those two cells. The staff also informed our inspectors they had submitted work orders to repair the non-working system for cells 10 and 15. However, neither cell 10 nor 15 was labeled to indicate the call system was not working for those cells, as deemed necessary by stakeholders to follow internal equipment failure and reporting policies.

[80] The OIG further noted the California Department of Public Health (CDPH) flex waiver for SVSP's CTC dated February 7, 2024, does not include waiver of the Title 22 requirement to maintain the operational call light system, and the CDPH flex waiver for SVSP's call light system dated November 28, 2023, is limited to the four areas of the Psychiatric Inpatient Program, and does not include the CTC.

Analysis of Performance Across Inspection Cycles

Table 25. Specialized Medical Housing, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SVSP continued to perform below established standards. The institution did not meet the 75.0 percent compliance threshold for this indicator, reaching only 57.1 percent in Cycle 8. More importantly, this score reflects continued regression from 70.0 percent in Cycle 6 and 67.9 percent in Cycle 7, highlighting significant need for improvement in this indicator.

Table 26. Specialized Medical Housing Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001)	6	0	0	100%
Was a written history & physical examination completed within the required time frame? (13.002)	4	2	0	66.7%
Upon the patient's admission to specialized medical housing: Did the provider order the medications within required time frames? (13.003.1)	6	0	0	100%
Upon the patient's admission to specialized medical housing: Were all ordered medications made available within required time frames? (13.003.2)	1	5	0	16.7%
Upon the patient's admission to specialized medical housing: Were all ordered medications administer or issued to the patient within required time frames? (13.003.3)	1	5	0	16.7%
For specialized health care housing: Do specialized health care housing maintain an operational call system? (13.101)	0	1	0	0
For specialized health care housing): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	1	0	0	100%
Overall percentage (MIT 13): **57.1%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- Medical leadership should identify any factors preventing specialized medical housing providers from timely documenting all pertinent history and physical examination findings and should implement and monitor remedial measures as appropriate.

Specialty Services

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

Specialty Services: Case Review Ratings and Results Summary

In this cycle, case review found SVSP performed satisfactorily in delivering specialty services for its patients. Most specialty service appointments occurred timely. The providers appropriately ordered specialty services and usually addressed the specialists' recommendations. Nurses generally assessed patients appropriately after return from off-site specialty service appointments. However, staff performed poorly in scanning specialty service reports, and providers occasionally missed or untimely endorsed the reports. After reviewing and considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 27. Case Review Specialty Services Results

Specialty-Services-Related Events*	Deficiencies†	Significant Deficiencies‡
67	21	2

* The OIG reviewed 67 events, which include 56 specialty consultations and procedures, six provider encounters, and five nursing encounters.

† Deficiencies occurred in cases 13–14, 17–18, 20, 25, 32–33, and 49.

‡ Significant deficiencies occurred in cases 13 and 33.

Performed Well

OIG clinicians found SVSP performed well in the following area:

- Provider performance[81]

Performed Satisfactorily, with Opportunities for Improvement:

OIG clinicians found SVSP performed satisfactorily with opportunities for improvement in the following areas:

- Access to Specialty Services

  OIG clinicians found most specialty appointments occurred within the requested time frames. We reviewed 56 specialty appointments and identified two late appointments, one of which was significant as follows:[82]

  - In case 33, the provider ordered paracentesis to occur in two weeks; however, the procedure occurred in three weeks, which was one week late.[83]

- Nursing Performance

  Nurses generally performed appropriate assessments, interventions, and documentation for patients returning from off-site specialty service appointments.[84] TTA and telemedicine nurses generally documented accurately and ordered provider follow-up appointments within the recommended time frames. However, OIG clinicians identified three minor deficiencies.[85] The following are two examples:

  - In case 33, the nurses did not obtain the patient's weight upon returning from paracentesis. On a separate event, the nurses documented symptoms of swelling but did not document the location of swelling.

[81] A minor deficiency occurred in case 25.

[82] Two late appointments occurred in case 33.

[83] Paracentesis is a medical procedure using a needle to remove excess fluid in the abdomen.

[84] Nursing staff assessed patients upon return from an off-site specialty appointment in cases 1, 18, 20, and 33.

[85] Three minor deficiencies occurred in case 33.

Performed Poorly, Improvement Needed

OIG clinicians found SVSP performed poorly with improvement needed in the following area:

- Health Information Management

  Staff performed poorly in scanning specialty service reports, as OIG clinicians identified a pattern of 11 deficiencies related to scanning specialty service reports late.[86] The following are examples:

  - In case 17, SVSP staff scanned an endocrinology specialty report nine days late.
  - In case 32, SVSP staff scanned a neurology specialty report 13 days late.

  In addition, although SVSP providers performed satisfactorily in endorsing specialty service reports, OIG clinicians identified four deficiencies related to late or missing endorsement specialty service reports, one of which was significant, as follows:[87]

  - In case 13, SVSP staff scanned a nephrology specialty report into the EHRS; however, the provider endorsed the report 25 days late.

Clinician On-Site Inspection

Photo 25. Physical therapy room. Photographed 2-19-26.

OIG clinicians met with medical and nursing leadership, providers, supervising registered nurses (SRN), specialty nurses (off site, on site, and telemedicine), and the utilization management (UM) nurse to discuss specialty services at SVSP. The off-site specialty nurse discussed the process of tracking patients who received off-site specialty and hospital care. TTA RNs managed patients returning from the off-site specialty services, scanned specialty reports and hospital records, and communicated to providers via general messaging. The nursing staff reported challenges with appointment availability of local off-site surgical specialty services for procedures. SVSP offered on-site specialty services, including optometry, hearing aids specialist, orthotics, gastroenterology

[86] Late scanning occurred in cases 14, 17, 32, and 33.

[87] Late or missing endorsements occurred in cases 13, 20, 33, and 49.

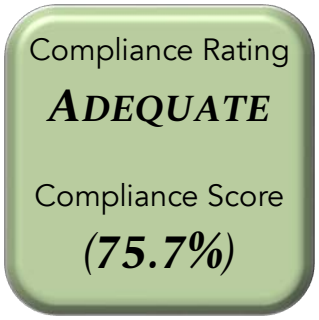
(esophagogastroduodenoscopy and colonoscopy), Holter monitor, sleep study, and physical therapy (PT).[88] The SRN explained the on-site PT will be phased out to virtual PT in SVSP.

Case Review Recommendations

- Medical leadership should develop strategies to ensure providers endorse specialty reports timely. Leadership should implement and monitor remedial measures as appropriate.

[88] An esophagogastroduodenoscopy is a procedure using a camera to examine the esophagus and the stomach. A Holter monitor is a portable device worn over a specified time period and used to detect abnormal heart rhythms.

Specialty Services: Compliance Ratings and Results Summary



SVSP exhibited sufficient performance in this indicator. Based on the overall compliance score result of 75.7 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- The institution demonstrated proficiency in ensuring patients received high-priority specialty services within 14 calendar days for 13 of 15 patients (MIT 14.001, 86.7%). For two patients, the services were provided one and 15 days late.
- The institution achieved proficiency in ensuring providers reviewed the high-priority specialty service consultant report within the required time frame for 13 of 14 sampled patients (MIT 14.002.2, 92.9%). For one patient, the provider reviewed the report two days late.
- The institution exhibited proficiency in providing subsequent follow-up appointments after a high-priority specialty service for eight of nine sampled patients (MIT 14.003, 88.9%). For one patient, the follow-up appointment occurred five days late from the provider's order.
- The institution achieved proficiency in ensuring providers reviewed the medium-priority specialty service consultant report within the required time frame for 12 of 13 sampled patients (MIT 14.005.2, 92.3%). For one patient, the provider reviewed the report two days late.
- The institution demonstrated proficiency in timely denying the Request for Services (RFS) as required by CCHCS policy for all 20 patients (MIT 14.011, 100%).

SVSP performed in the ***adequate*** range in the following sub-indicators:

- The institution achieved sufficient performance in ensuring patients received medium-priority specialty services within 15 to 45 calendar days for 12 of 15 patients (MIT 14.004, 80.0%). For three patients, the services were provided between two and 27 days late.
- The institution achieved sufficient performance in ensuring providers reviewed the routine-priority specialty service consultant report within the required time frame for 11

of 14 sampled patients (MIT 14.008.2, 78.6%). For three patients, the provider reviewed the report between two and 25 days late.

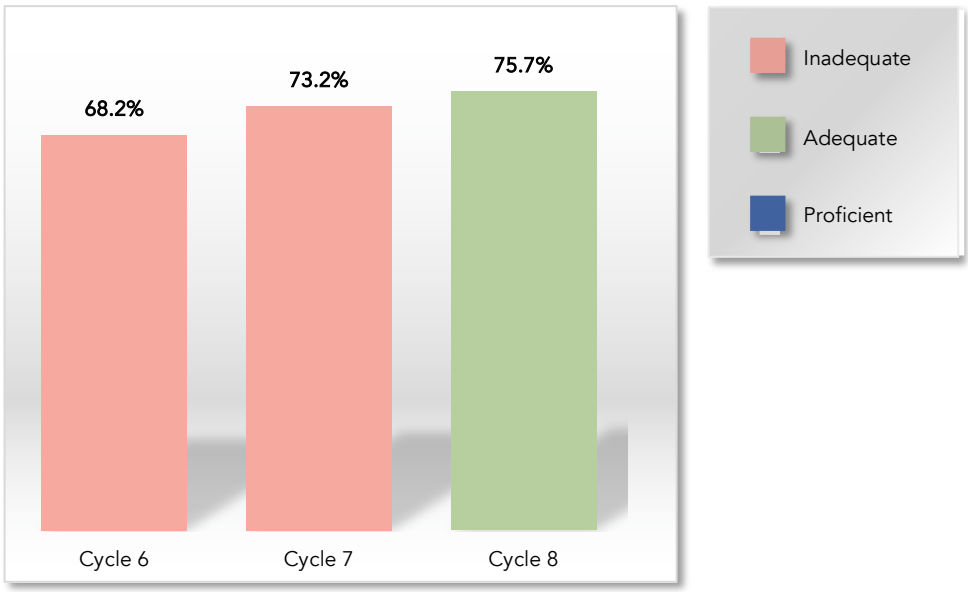
- We found opportunities for improvement in providing subsequent follow-up appointments after a routine-priority specialty service for six of eight sampled patients (MIT 14.009, 75.0%). For one patient, the follow-up appointment occurred four days late from the provider's order. For the remaining patient, the record contained no evidence that a refusal form was completed.

SVSP performed in the ***inadequate*** range in the following sub-indicators:

- The institution received high-priority specialty service consultant reports within the required time frame for 10 of 14 sampled patients (MIT 14.002.1, 71.4%). For four patients, the reports were received between one and 17 days late.
- The institution received medium-priority specialty service consultant reports within the required time frame for seven of 11 sampled patients (MIT 14.005.1, 63.6%). For four patients, the reports were received between one and six days late.
- The institution ensured patients timely received their routine-priority specialty services within 90 calendar days for 10 of 15 patients (MIT 14.007, 66.7%). For four patients, the services were provided between 17 and 75 days late. For the remaining patient, the record contained no evidence the specialty appointment ever occurred while the patient was housed in SVSP.
- The institution received routine-priority specialty service consultant reports within the required time frame for eight of 13 sampled patients (MIT 14.008.1, 61.5%). For five patients, the reports were received between one and seven days late.
- The institution ensured patients timely received their pre-approved specialty service appointments for patients endorsed from another institution in only 13 of 20 sampled patients (MIT 14.010, 65.0%). For six patients, the services were provided between four and 41 days late. For the remaining patient, the record contained no evidence the specialty service appointment occurred during our review period.
- Providers informed 13 of 19 sampled patients of the denied RFS within the required time frame (MIT 14.012, 68.4%). For five patients, the record contained no evidence the provider discussed the denied specialty service request with the patient. For the remaining patient, the provider informed the patient of the denied service 29 days late.

Analysis of Performance Across Inspection Cycles

Figure 9. Specialty Services, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SVSP attained the established standards for providing Specialty Services. The institution met the 75.0 percent compliance threshold for this indicator, reaching 75.7 percent in Cycle 8. This rating reflects steady progress from 68.2 percent in Cycle 6 and 73.2 percent in Cycle 7, which demonstrates a successful commitment to improvement.

Table 28. Specialty Services Compliance Test Scores

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)	13	2	0	86.7%
Did the institution receive the high-priority specialty service consultant report within the required time frame? (14.002.1)	10	4	1	71.4%
Did the institution review the high-priority specialty service consultant report within the required time frame? (14.002.2)	13	1	1	92.9%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.003)	8	1	6	88.9%
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)	12	3	0	80.0%
Did the institution receive the medium-priority specialty service consultant report within the required time frame? (14.005.1)	7	4	4	63.6%
Did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005.2)	12	1	2	92.3%
Did the patient receive the subsequent follow-up to the medium- priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.006)	4	5	6	44.4%
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)	10	5	0	66.7%
Did the institution receive the routine-priority specialty service consultant report within the required time frame? (14.008.1)	8	5	2	61.5%
Did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008.2)	11	3	1	78.6%
Did the patient receive the subsequent follow-up to the routine- priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.009)	6	2	7	75.0%
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)	13	7	0	65.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	20	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	13	6	1	68.4%
Overall percentage (MIT 14): **75.7%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

- The department should develop measures to ensure institutions timely receive specialty reports. Leadership should implement and monitor remedial measures as appropriate.
- Health care leadership should develop strategies to ensure patients timely receive pre-approved specialty services and subsequent follow-up specialty appointments. Leadership should implement and monitor remedial measures as appropriate.

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.

In previous cycles, the OIG did not include the score or rating for this indicator in the institution's overall compliance assessment. However, beginning with Cycle 8, the OIG determined adherence to administrative operations should be considered a primary factor because these requirements ensure health care staff are sufficiently certified and trained to provide quality medical care to patients. Therefore, this indicator's individual score is included in the institution's overall compliance rating.

Administrative Operations: Compliance Ratings and Results Summary

SVSP performed outstandingly in this indicator. Based on the overall compliance score result of 92.3 percent, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Testing Results

SVSP performed in the ***proficient*** range in the following sub-indicators:

- The institution's Quality Management Committee (QMC) consistently met monthly during our review period (MIT 15.002, 100%).
- The institution's Local Governing Body (LGB) met quarterly and discussed local operation procedures and any applicable policies during our review period (MIT 15.003, 100%).

- The institution responded to the medical grievances and addressed all 10 patient appeals during our review period (MIT 15.101, 100%).
- Supervising registered nurses ensured the clinical competency of all nurses administering medications were timely completed during our review period (MIT 15.103, 100%).
- All 12 providers maintained valid state medical licenses (MIT 15.105, 100%).
- Nurses and the pharmacist-in-charge (PIC) maintained valid professional licenses and certifications. In addition, the institution's pharmacy had current pharmacy licenses (MIT 15.106, 100%).
- The pharmacy and providers maintained valid DEA registration. In addition, the pharmacy maintained valid Automated Drug Delivery System (ADDS) licenses (MIT 15.107, 100%).
- The institution ensured all newly hired nurses received the required onboarding and clinical competency timely (MIT 15.108, 100%).

SVSP performed in the ***adequate*** range in the following sub-indicators:

- The institution reviewed and completed the initial patient death reports timely for eight of 10 sampled patients (MIT 15.102, 80.0%). For two patients, the reports were not completed within the required time frames.
- The medical leadership completed three of four clinicians' performance appraisals timely (MIT 15.104, 75.0%). For one clinician, the performance evaluation was not timely completed.

SVSP performed in the ***inadequate*** range in the following sub-indicators:

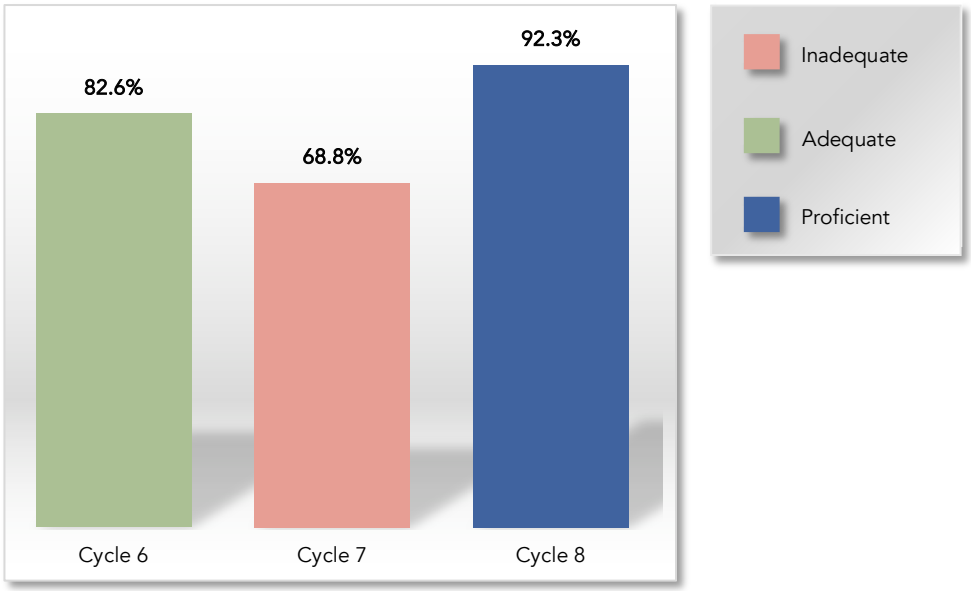
- We obtained CCHCS Mortality Case Review reporting data. The institution's CEO and its designee(s) completed the multidisciplinary review of the significant events leading to six of 10 sampled patients during our review period (MIT 15.998 [scored component], 60.0%). Four reviews contained deficiencies, including incomplete review dates and documentation dates prior to the patient's date of death.

The following test(s) are not scored but are reported for informational purposes:

- At SVSP, the OIG did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001, N/A).
- For the other portion of the mortality review testing, we found no evidence in the submitted documentation the preliminary mortality reports were completed for all 10 patients. These reports were overdue at the time of the OIG's inspection (MIT 15.998 [non-scored component], N/A).

Analysis of Performance Across Inspection Cycles

Figure 10. Administrative Operations, Compliance Scores Across Cycles



Source: OIG SVSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SVSP performed excellently, surpassing established standards, and improved from ***inadequate*** in Cycle 7 to ***proficient*** in Cycle 8. The institution significantly exceeded the 75.0 percent compliance threshold for this indicator, reaching 92.3 percent in Cycle 8. This reflects significant progress from 82.6 percent in Cycle 6 and 68.8 percent in Cycle 7, demonstrating an outstanding commitment to improvement.

Table 29. Administrative Operations Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For informational purposes only: For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This test is not scored. 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 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? (15.003)	4	0	0	100%
Did the responses to medical grievances address all of the patients' appealed issues? (15.101)	10	0	0	100%
Did the medical staff review and submit initial patient death reports timely? (15.102)	8	2	0	80.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.103)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.104)	3	1	6	75.0%
Did the providers maintain valid state medical licenses? (15.105)	12	0	0	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? (15.106)	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? (15.107)	1	0	1	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.108)	13	0	0	100%
Did the institution's CEO or designee(s) complete a multidisciplinary review of the significant events leading to the patient's death timely? For informational purposes only Did the Headquarters Mortality Case Review process mortality review reports timely (15.998)	6	4	0	60.0%
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This test is not scored. Please refer to Table 4 for CCHCS- provided staffing information.			
Overall percentage (MIT 15): **92.3%**				

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov.

Compliance Recommendations

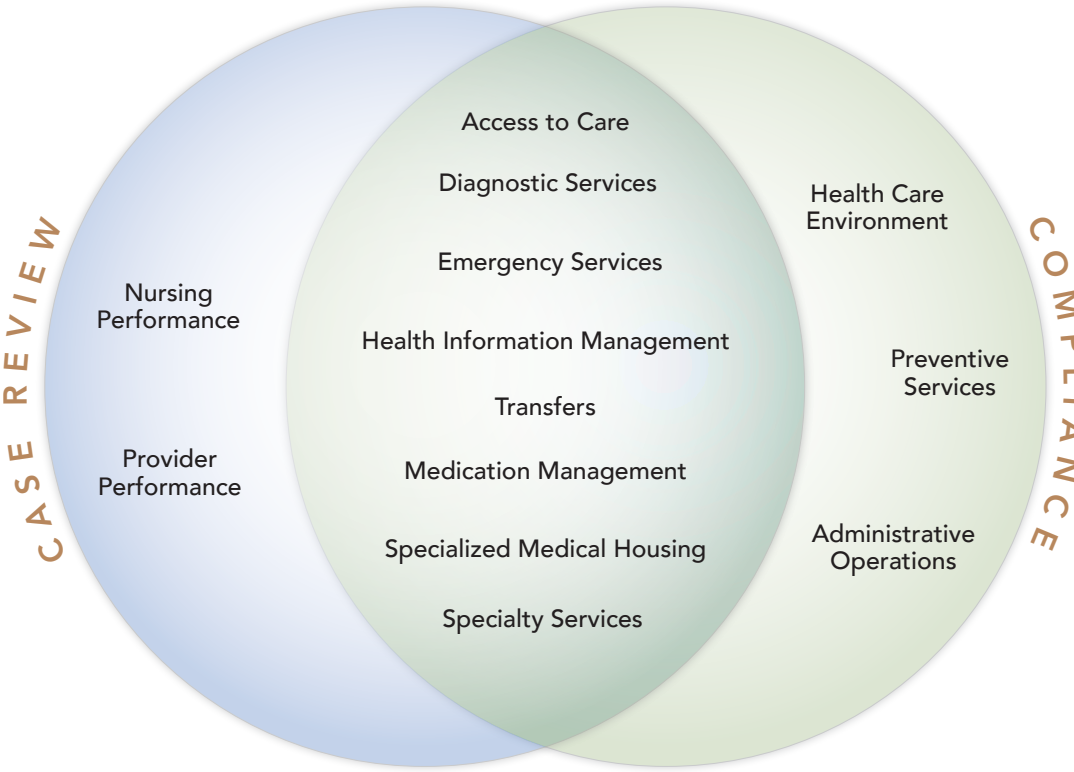
The OIG offers no compliance recommendations for this indicator.

Appendix A: Methodology[89]

In designing the medical inspection program, the OIG met with stakeholders to review California Correctional Health Care Services' (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 California Department of Corrections and Rehabilitation, 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 8 below depicts the intersection of case review and compliance.

Figure 11. Inspection Indicator Review Distribution for SVSP



[89] OIG Methodology: https://www.oig.ca.gov/dataExplorer/MIU%20Case%20Review%20Methodology.pdf

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 30. 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

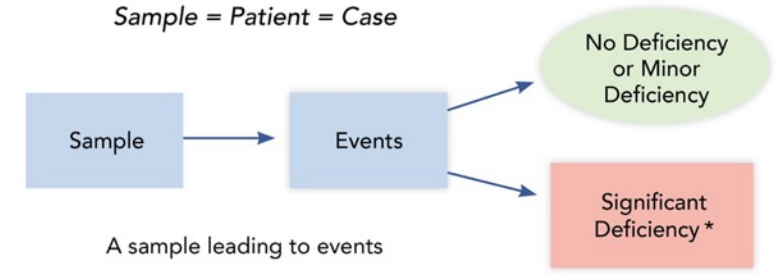
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

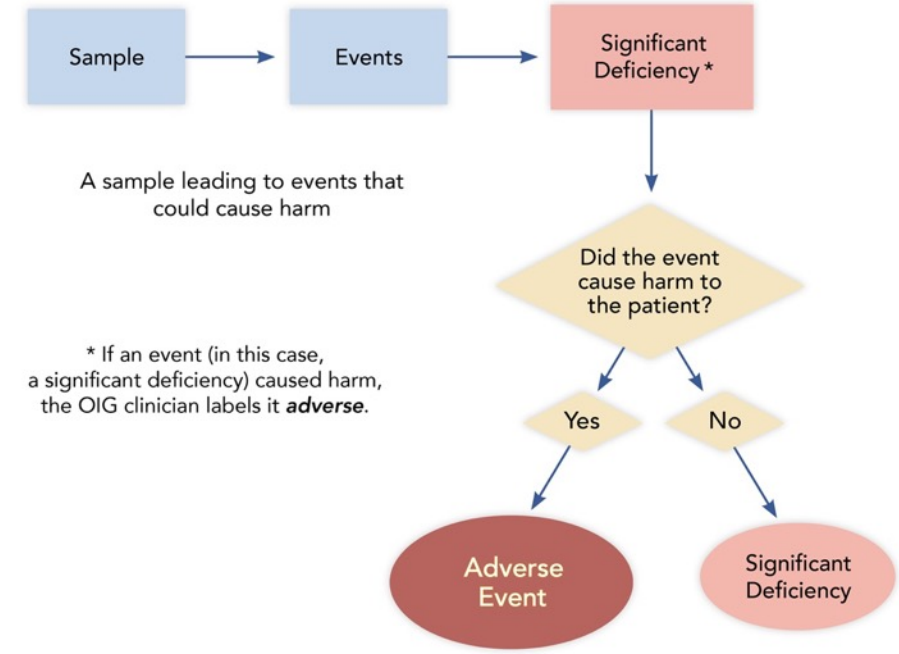
Figure 12. Case Review Testing

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.

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 31. SVSP Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	4
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	3
Hospitalization	3
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	14
Specialty Services	2
	48

Table 32. SVSP Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	4
Anticoagulation	6
Arthritis/Degenerative Joint Disease	2
Asthma	7
Cancer	4
Cardiovascular Disease	2
Chronic Kidney Disease	4
Chronic Pain	15
Cirrhosis/End-State Liver Disease	3
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	9
Gastroesophageal Reflux Disease (GERD)	9
Gastrointestinal Bleed	1
Hepatitis C	21
Hyperlipidemia	17
Hypertension	23
Mental Health	33
Migraine Headaches	3
Rheumatological Disease	1
Seizure Disorder	6
Sleep Apnea	4
Substance Abuse	31
Thyroid Disease	4
	211

Table 33. SVSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	198
Emergency Care	217
Hospitalization	57
Intra-System Transfers In	6
Intra-System Transfers Out	9
Outpatient Care	461
Specialized Medical Housing	45
Specialty Services	95
	1088

Table 34. SVSP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	1
RN Reviews Detailed	14
RN Reviews Focused	25
Total Reviews	60
Total Unique Cases	48
Overlapping Reviews (MD & RN)	12

Appendix C: Compliance Sampling Methodology

Salinas Valley State Prison

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 (1–7 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	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 (30 days–7 months) • Randomize
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (30 days–7 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (30 days–7 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 2.010-012	Pathology	10	InterQual	• Appt. date (30 days–7 months) • Service (pathology-related) • Randomize
Emergency Services				
MIT 3.001	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MITs 3.101-103	Clinical Areas	11	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
MIT 3.104	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 3.105	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
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	25	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	25	Documents for any tested incarcerated person	• Arrival date (12 months) • Any misfiled or mislabeled document identified during OIG compliance review • Randomize
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site admissions	• Date (1–7 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				• Randomize
Health Care Environment				
MITs 5.101-105 MITs 5.107-111	Clinical Areas	11	OIG inspector on-site review	• Identify and inspect all on-site clinical area
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (1–7 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
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	25	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	25	MAPIP transfer data	• Date of transfer (1–7 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				• Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (1–7 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 • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	10	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units
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				

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 9.001-002	TB Medications	6	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	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 (age 45 –75) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 40 –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 21 – 65) • 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 bus days prior to inspection date) • All
Reception Center				
MITs 12.001-	RC	N/A at this	SOMS	• Arrival date (1–7 months)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
007		institution		• Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001-003	Specialized Health Care Housing Unit	6	CADDIS	• Admit date (1–7 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,

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
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	20	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 (12 months)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.102	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Provider Annual Evaluation Packets	10	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.105	Provider Licenses	12	Current provider listing (at start of inspection)	• Review all
MIT 15.106	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 15.107	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.108	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

California Correctional Health Care Services' Response

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June 17, 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 case review and compliance draft indicators for the Office of the Inspector General's Cycle 8 medical inspection of Salinas Valley State Prison. Thank you for preparing the report.

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

Sincerely,

DocuSigned by:
DeAnna M. Gouldy
3B7F6B95AC0A4D1...

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Sarah Hartmann, Chief Counsel, CCHCS Office of Legal Affairs
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Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Rainbow Brockenborough, Deputy Director, Institution Operations, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
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Chief Executive Officer, SVSP
Heather Pool, Chief Assistant Inspector General, OIG
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Amanda Elhardt, Report Coordinator, OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

Cycle 8

Medical Inspection Report

for

Salinas Valley State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2026

OIG