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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

June 2026

Substance Abuse Treatment Facility and State Prison at Corcoran

Medical Inspection Report

Cycle 8

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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. In addition, 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 evaluate emergency care, we relocated four compliance sub-indicator tests relating to emergency services into a new compliance indicator, "**Indicator 3. Emergency Services**," to supplement the case review findings under this indicator.[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 to reflect 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 accordance with the legislature's interest in focusing on the undelegated institutions, the OIG scheduled our 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 the Substance Abuse Treatment Facility and State Prison at Corcoran (SATF), the receiver had not yet delegated the institution back to the department.

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[4] The following four compliance tests were each relocated to **Indicator 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 Indicator 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 Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) in March 2026.[7] OIG inspectors monitored the institution's delivery of medical care that occurred during the specified review periods.

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

The OIG rated the compliance component of the overall health care quality at SATF as ***inadequate*** (**74.7%**).

OIG case review clinicians—a team of Physicians & Surgeons (physicians) and Nursing Consultants, Program Review (NCPRs)—reviewed 56 cases, which contained 817 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 March 2026 to verify their initial findings. OIG clinicians evaluated the quality of care for a total of 71 case reviews that included both physician and NCPR comprehensive detailed case reviews and focused case event reviews.[8]

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

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

[8] For our detailed and focused case reviews, our clinicians reviewed medical charts and events for 56 unique patients. Both physicians and NCPRs reviewed 15 of those cases, for a total of 71 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.[9]

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)[10] 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 436 patient records and 1,291 data points, and we used the data to assess 101 MIT questions. We also observed SATF's processes during an on-site inspection in February 2026.

The OIG then considered the results from both our clinical case review and compliance testing, and we determined the institution's overall ratings and our individual indicator findings, which we report in 13 health care indicators.[11]

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[9] For a further discussion of an adverse event, see Table 29.

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

[11] The indicators **Reception Center** and **Prenatal and Postpartum Care** did not apply to SATF.

Overall Medical Inspection Results

Case Review Results

OIG case reviewers assessed 10 of the 13 indicators applicable to SATF. OIG clinicians rated one of these indicators ***proficient***, six ***adequate***, and three ***inadequate***. In the 817 events reviewed, we identified 364 deficiencies, 126 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, they 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 SATF during the Cycle 8 inspection.

Compliance Testing Results

Our compliance inspectors assessed 11 of the 13 indicators applicable to SATF. Of these 11 indicators, our compliance inspectors rated two ***proficient***, six ***adequate***, and three ***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. SATF 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: Cycle 8	Case Review: Change Since Cycle 7*	Compliance: Cycle 8	Compliance: Cycle 7	Compliance: Change
1	Access to Care	*Proficient*	↑	*79.8%*	*78.3%*	=
2	Diagnostic Services	*Adequate*	=	*78.9%*	*58.9%*	↑
3	Emergency Services	*Adequate*	=	*33.3%*	*N/A*	
4	Health Information Management	*Adequate*	↑	*80.7%*	*81.0%*	=
5	Health Care Environment	*N/A*	*N/A*	*79.6%*	*45.1%*	↑
6	Transfers	*Adequate*	=	*88.6%*	*75.8%*	↑
7	Medication Management	*Inadequate*	↓	*54.8%*	*42.2%*	=
8	Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*	*N/A*	
9	Preventive Services	*N/A*	*N/A*	*81.8%*	*76.9%*	=
10	Nursing Performance	*Adequate*	=	*N/A*	*N/A*	
11	Provider Performance	*Inadequate*	↓	*N/A*	*N/A*	
12	Reception Center	*N/A*	*N/A*	*N/A*	*N/A*	
13	Specialized Medical Housing	*Inadequate*	↓	*70.0%*	*66.7%*	=
14	Specialty Services	*Adequate*	=	*84.8%*	*71.8%*	↑
15	Administrative Operations	*N/A*	*N/A*	*89.8%*	*71.9%*	↑↑

* 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

Substance Abuse Treatment Facility and State Prison at Corcoran (SATF), located in Kings County, operates as a medium-to-high-security, and maximum-security institution for general population incarcerated people. SATF maintains medical clinics where medical staff address routine requests for medical services. SATF also conducts patient screenings in its receiving and release clinic (R&R), treats patients requiring urgent or emergent care in its triage and treatment area (TTA), and houses patients requiring inpatient health care services in its correctional treatment center (CTC). SATF has been designated as a "basic" care institution by the department. Basic care institutions are located in rural areas away from tertiary care centers and specialty care providers whose services are likely to be used frequently by higher-risk patients. Basic care institutions have the capability to provide limited specialty medical services and consultation for a generally healthy incarcerated population.[12]

On December 8, 2025, the Health Care Services Master Registry showed SATF had a total population of 5,458. A breakdown of the medical risk level of the SATF population as determined by the department is set forth in Table 2 below.[13]

Table 2. SATF Master Registry Data as of December 2025

Medical Risk Level	Number of Patients	Percentage*
High 1	496	9.1%
High 2	698	12.8%
Medium	2,853	52.3%
Low	1,411	25.9%
Total	**5,458**	**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 December 08, 2025.

[12] Institutions designated as "basic" are generally expected to have a high-risk medical population of approximately 5 percent. At over 22 percent, SATF'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 SATF's designation and patient complexity may account for some deficiencies we identified.

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, SATF had 1.0 vacant executive leadership position, 5.0 primary care provider vacancies, 1.2 nursing supervisor vacancies, and 37.8 nursing staff vacancies.

Table 3. SATF Health Care Staffing Resources as of December 2025

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions‡	6.0	17.0	24.2	262.3	309.5
Filled by Civil Service	5.0	12.0	23.0	224.5	264.5
Vacant	1.0	5.0	1.2	37.8	45.0
Percentage Filled by Civil Service	83.3%	70.6%	95.0%	85.6%	85.5%
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	0.0	0.0	0.0	0.0
Percentage Filled by Registry	0.0%	0.0%	0.0%	0.0%	0.0%
Total Filled Positions	5.0	12.0	23.0	224.5	264.5
Total Percentage Filled	83.3%	70.6%	95.0%	85.6%	85.5%
Appointments in Last 12 Months	1.0	2.0	5.0	56.0	64.0
Redirected Staff	0.0	0.0	0.0	0.0	0.0
Staff on Extended Leave‡	0.0	0.0	0.0	4.0	4.0
Adjusted Total: Filled Positions	5.0	12.0	23.0	220.5	260.5
Adjusted Total: Percentage Filled	83.3%	70.6%	95.0%	84.1%	84.2%

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 8 medical inspection pre-inspection questionnaire received on December 08, 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 SATF'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)—SATF'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. SATF had a 47-percent influenza immunization rate for adults 18 to 64 years old and a 78-percent influenza immunization rate for adults 65 years of age and older. 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) — SATF had a 71-percent colorectal cancer screening rate, a rate higher and thus better than California Medi-Cal and equal to both Kaiser Southern California (Medi-Cal) and Kaiser Northern California (Medi-Cal).

Table 4. SATF Results Compared to State HEDIS Scores

HEDIS Measure	SATF Cycle 8 Results*	California Medi-Cal†	Kaiser NorCal Medi-Cal†	Kaiser SoCal Medi-Cal†
Diabetic Population				
Poor HbA1c Control (>9.0%) ‡, §	**8%**	33%	26%	19%
HbA1c Control (<8.0%) ‡	87%	–	–	–
Blood Pressure Control (<140/90) ‡	93%	–	–	–
HbA1c Screening	100%	–	–	–
Eye Exams	51%	–	–	–
Immunizations				
Influenza - Adults (18–64)	47%	–	–	–
Influenza - Adults (65+)	78%	–	–	–
Pneumococcal – Adults (65+)	90%	–	–	–
Cancer Screening				
Colorectal Cancer Screening	**71%**	40%	**71%**	**71%**

* Unless otherwise stated, data were collected in January 2026 by reviewing medical records from a sample of SATF'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 SATF 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.

Case Review Ratings and Results Summary

In this cycle, case review found SATF performed very well overall in delivering access to care for its patients, similar to Cycle 7. Staff performed excellently in ensuring timely access to clinic nurses; providers in specialized medical housing; and follow-up after specialty services, hospitalizations, emergent care, and transfer into the institution. Patients also received good access to clinic providers and specialty services. Considering all aspects of access to care, the OIG rated the case review component of this indicator ***proficient***.

Table 5. Access to Care Case Review Results

Total Cases Reviewed*	Deficiencies†	Significant Deficiencies‡
56	7	3

* The OIG reviewed 56 cases.
† Deficiencies occurred in cases 13, 20, 35, 36, and 39.
‡ Significant deficiencies occurred in cases 13 and 20.

Performed Well

OIG clinicians found SATF performed well in the following areas:

- Access to Clinic Nurses[14]
- Access to SMH Providers[15]
- Follow-up After Specialty Services[16]
- Follow-up After Hospitalizations[17]
- Follow-up After Urgent or Emergent Care[18]
- Follow-up After Transferring into SATF[19]

Performed Satisfactorily, with Opportunities for Improvement

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

- Access to Clinic Providers[20]

  Providers usually evaluated patients within specified time frames as ordered. OIG clinicians identified two deficiencies, one of which was significant. The following is an example:

  - In case 13, the nurse assessed the patient at a sick call appointment for a complaint of a right chest lump. The nurse ordered a provider appointment to further evaluate the chest lump. However, the provider did not evaluate the patient for this medical symptom during the review period.

- Access to Specialty Services[21]

  Specialty appointments usually occurred within the requested time frames. OIG clinicians identified three deficiencies related to access to specialty services, two of

[14] Minor deficiencies occurred in cases 36 and 39.
[15] OIG clinicians identified no deficiencies in this sub-indicator.
[16] OIG clinicians identified no deficiencies in this sub-indicator.
[17] OIG clinicians identified no deficiencies in this sub-indicator.
[18] OIG clinicians identified no deficiencies in this sub-indicator.
[19] OIG clinicians identified no deficiencies in this sub-indicator.
[20] Deficiencies occurred in cases 13 and 35. A significant deficiency occurred in case 13.
[21] Deficiencies occurred in cases 13 and 20. Two significant deficiencies occurred in case 20.

which were significant. We discuss this further in the **Specialty Services** indicator. The following is an example:

- In case 20, the provider ordered a cardiology specialty follow-up appointment; however, the cardiology appointment occurred over seven weeks late.

Performed Poorly, Improvement Needed

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

Clinician On-Site Inspection

OIG clinicians met with the outpatient scheduling supervisor to discuss SATF's clinics and appointment processes. The supervisor reported SATF operates 10 outpatient clinics as well as the correctional treatment center (CTC) for inpatient patient care and triage and treatment area (TTA) for urgent and emergent patient care. The outpatient clinics are assigned up to two providers each.

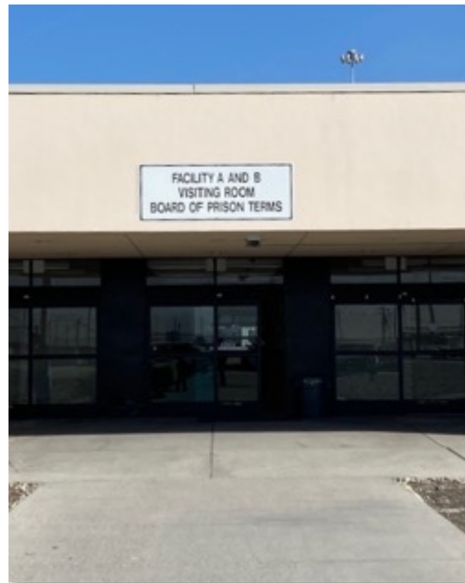


Photo 1. Entrance to Facility A and B. Photographed on 3-17-2026.

The supervisor stated three office technician (OT) scheduler positions were vacant during the review period from July 2025 to January 5, 2026. Subsequently, the three vacant positions were filled on September 2025, December 2025, and January 2026. The supervisor mentioned the OT positions were vacant due to promotions or retirements, but the scheduling unit was able to hire staff because surrounding towns 30 to 40 minutes from SATF offered available recruiting.

Finally, the supervisor reported no current provider clinic appointment backlog because SATF maintains weekend medical clinics with on-site and telemedicine staff to offer patient appointments.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

Access to Care: Compliance Ratings and Results Summary

SATF performed satisfactorily in this indicator. Based on the overall compliance score result of 79.8 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- The institution exceptionally ensured most recent chronic care appointments were conducted for 24 of 25 sampled patients within the specified time frame (MIT 1.001, 96.0%). For one patient, the appointment occurred 68 days late.

- Following the review of the patients' submitted health care service request forms (CDCR Form 7362), registered nurses (RN) excellently completed face-to-face appointments for 34 of 36 sampled patients within one business day (MIT 1.004, 94.4%). For two patients, we found one or more of the following deficiencies: the RN face-to-face encounter was one day late and nursing staff failed to document the visit using the required Subjective, Objective, Assessment, and Plan (SOAP) note format.

- In 22 applicable samples where a registered nurse identified the need for a primary care referral, 20 patients were seen within the required time frame (MIT 1.005, 90.9%) according to the priority level assigned to their appointment. For two patients, the appointments occurred between one and 28 days late.

- 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%).

- The institution implemented a standardized process for the acquisition and submission of CDCR Forms 7362, ensuring a consistent process for all patients and resulting in a perfect score (MIT 1.101.2, 100%).

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

- Providers satisfactorily completed post-discharge follow-up appointments for 18 of 23 sampled patients within the required time frame (MIT 1.007, 78.3%). For three patients, the appointments occurred between one and seven days late. For one patient, the record contained no evidence staff completed a refusal form during our review period. For the remaining patient, the record contained no evidence the face-to-face visit occurred during our review period.

- The institution consistently 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 did not receive a follow-up appointment, the primacy care team (PCT) provided the required timely notification of the specialist's recommendations in 32 of 38 sampled patients (MIT 1.008, 84.2%). For two patients, the primary care provider (PCP) follow-up appointment after a high-priority specialty service occurred between three and seven days late. For two patients, the record contained no evidence of a PCP appointment following a high-priority specialty service within our review period. For one patient, the PCP follow-up appointment after a medium-priority specialty service occurred two days late. For the remaining one patient, the record contained no evidence staff completed a refusal form during our review period.

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

- When new patients arrived at the institution, the patients must either be assessed by an RN or evaluated by a provider, depending on their clinical risk level. Of the 25 patients we sampled, providers maintained their workflows and completed their comprehensive patient appointments for all 11 patients referred for provider appointment. However, nurses completed only two of the 14 remaining patients who required RN assessments. For 12 patients, the record contained no evidence of the required interfacility RN appointment occurring within our review period. This led to a combined score of only 13 of 25 patients receiving the appropriate care upon arriving to the institution (MIT 1.002, 52.0%).

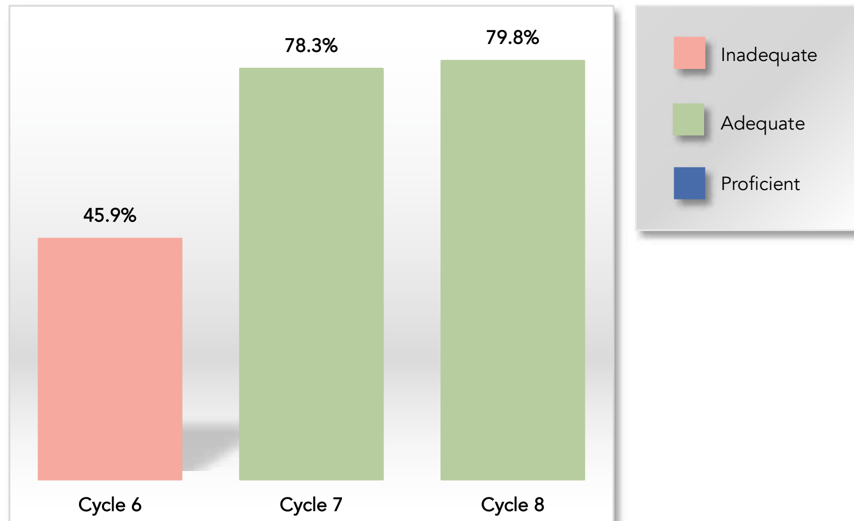
- Nursing staff performed poorly in adhering to triage documentation standards; only nine of 40 sampled patients met the full requirements for a completed review upon receipt of the CDCR Form 7362 (MIT 1.003, 22.5%). For 31 patients, nursing staff failed to accurately complete the CDCR Form 7362 with the required receipt date and time, printed or stamped name, title, and signature.

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

- The institution implemented a standardized process for the replenishment of CDCR Forms 7362, for which custody officers coordinate through the program office to ensure an adequate supply is maintained for all patients (MIT 1.101.1, N/A).

Analysis of Performance Across Inspection Cycles

Figure 1. Access to Care, Compliance Scores Across Cycles



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

SATF consistently exceeded the 75.0-percent compliance threshold in most tests, maintaining a strong performance of 79.8 percent in Cycle 8. This demonstrates a steady improvement from SATF's performance of 78.3 percent in Cycle 7 and 45.9 percent in Cycle 6. The institution continues to meet established standards for access to care.

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)	24	1	0	96.0%
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)	13	12	0	52.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	9	31	0	22.5%
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)	34	2	4	94.4%
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)	20	2	18	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	39	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)	18	5	2	78.3%
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)	32	6	7	84.2%
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): **79.8%**				

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 properly process medical requests (CDCR Form 7362) and complete all required documentation. Leadership should implement and monitor remedial measures as appropriate.

- Health care leadership should determine the root causes of untimely clinic nursing visits upon patient arrival at the institution and 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.

Case Review Ratings and Results Summary

In this cycle, case review found SATF performed sufficiently with diagnostic services. Staff almost always completed diagnostic tests on time. However, similar to Cycle 7, providers often either sent incomplete or did not send test result notification letters to patients. After considering all aspects, the OIG rated the case review component of this indicator ***adequate.***

Table 7. Diagnostic Services Case Review Results

Diagnostic Events*	Deficiencies†	Significant Deficiencies‡
142	85	6

* The OIG reviewed diagnostic services 142 events.

† Deficiencies occurred in cases 1, 2, 8, 9, 11, 12–20, 22, 25, and 32. Of these 85 deficiencies, 70 related to incomplete or lack of patient notification letters, 12 related to untimely or lack of test result endorsements, one related to late record scanning, one related to a misfiled and mislabeled document, and one related to late completion of an imaging test.

‡ Significant deficiencies occurred in cases 14, 17, and 22.

Performed Well

OIG clinicians found SATF performed well in the following area:

- Test completion[22]

Performed Satisfactorily, with Opportunities for Improvement

OIG clinicians found no areas in this indicator in which SATF performed satisfactorily, with opportunities for improvement.

[22] A minor deficiency in test completion occurred in case 25.

Performed Poorly, Improvement Needed

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

- Health Information Management

  Many of the diagnostic deficiencies related to health information management. We identified 84 deficiencies, six of which were significant.[23] The deficiencies related to incomplete or missing test result notification letters to patients, untimely or lack of provider endorsement of test results, late scanning, and misfiled or labeled documentation.[24] The following are examples of significant deficiencies:

  - In case 14, abnormal test results became available for review. However, the provider did not review and sign the results until 20 days later. Furthermore, the provider did not create a patient test result notification letter in the EHRS.[25]

  - In case 17, the provider endorsed the laboratory test results seven days late.

  - In case 22, the provider endorsed laboratory test results and created a patient letter 14 days after the test results were available.

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[23] Deficiencies in health information management occurred in cases 1, 2, 8, 9, 11–20, 22, 25, and 32. Significant deficiencies occurred in cases 14, 17, and 22.

[24] Deficiencies related to incomplete or lack of sending test result notification letters to patients occurred in cases 1, 2, 8, 9, 11–17, 19, 20, 22, 25, and 32. Deficiencies related to untimely or lack of provider endorsement of test results occurred in cases 14, 17, 18, and 22. A deficiency in late scanning occurred in case 2. A deficiency in misfiled and mislabeled documentation occurred in case 9.

[25] EHRS is the Electronic Health Records System, which is the department's system for storing a patient's medical history. Health care staff use the system to communicate with one another.

Clinician On-Site Inspection

Photo 2. Entrance door to the laboratory collection area.
Photographed 3-17-2026.

We met with the diagnostics health program manager III and laboratory supervisor to discuss SATF diagnostic processes and went to the radiology and laboratory areas. At the radiology area, a radiology technician (RT) was not on site. The manager reported the full-time radiology technician position was currently vacant and expressed difficulty in hiring for this position, but the manager noted CCHCS human resources was assisting to find qualified candidates. The supervisor stated many qualified candidates lived in the Bakersfield and Fresno areas; however, the commuting distance was a factor for those candidates in accepting the position at SATF. A new part-time radiology technician was in training and would be on site Monday through Wednesday. SATF also used staff from other institutions to assist in completing on-site radiology tests. A California State Prison, Corcoran, radiology technician was on site at SATF on Monday through Friday from 3pm to 8pm. In addition, a Pleasant Valley State Prison radiology technician operated a SATF radiology clinic on Saturdays to help with the backlog. Besides the x-rays, the RT also scheduled the x-rays and specialty on-site imaging services such as CT, MRI, Fibroscan, and ultrasound.[26] The manager reported minimal backlogs because the specialty services on-site imaging vendor offered extra appointments when needed.

The laboratory supervisor stated the laboratory positions were fully occupied, and most laboratory employees had been at SATF for over five years. She stated the most common reason for employees leaving was for further career education; otherwise, staff recruitment and retention had not been problematic. Employees had even transferred from California State Prison, Corcoran, and Pleasant Valley State Prison in the past. When asked about the success of retention, the supervisor mentioned staff members enjoy working at SATF.

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 liver scarring and fatty changes from liver disease.

Diagnostic Services: Compliance Ratings and Results Summary

SATF performed satisfactorily in this indicator. Based on the overall compliance score result of 78.9 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- The institution's radiology staff delivered excellent diagnostic services for nine of 10 sampled patients within required time frames (MIT 2.001, 90.0%). For one patient, the high-priority radiology service order was not performed timely.
- Providers demonstrated proficiency in reviewing and endorsing radiology reports for all 10 sampled patients (MIT 2.002, 100%).
- Providers demonstrated proficiency in timely reviewing and endorsing laboratory reports for all 10 sampled patients (MIT 2.005, 100%).
- SATF received pathology reports for all 10 sampled patients within required time frames (MIT 2.010, 100%).
- Providers demonstrated proficiency in timely reviewing and endorsing pathology reports for all 10 sampled patients (MIT 2.011, 100%).

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

- Laboratory services consistently completed orders for eight of 10 sampled patients within the time frames specified (MIT 2.004, 80.0%). For two patients, the laboratory services ordered as timed studies were not performed within the specified time frames.
- Healthcare providers generated patient notification letters for laboratory reports with all required elements within specified time frames for eight of 10 sampled patients (MIT 2.006, 80.0%). For one patient, the patient letter was missing key elements as required by policy. For the remaining one patient, the record contained no evidence of a generated patient letter communicating laboratory results.

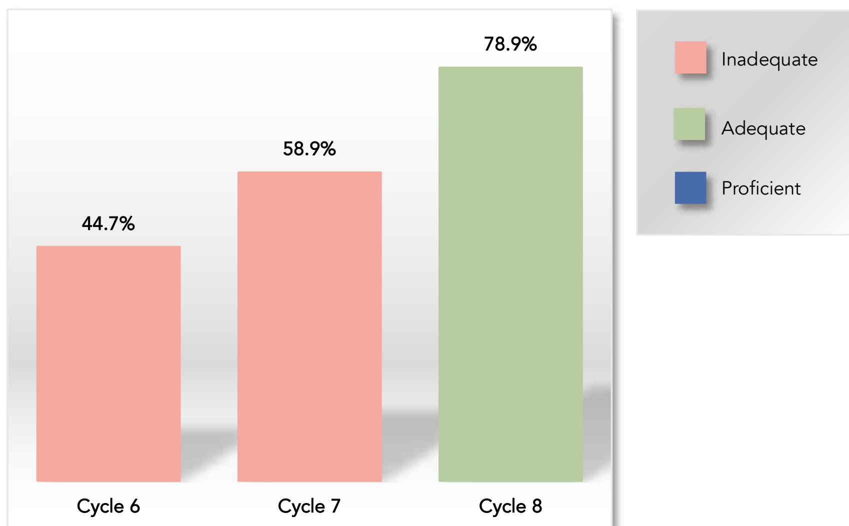
SATF performed in the ***inadequate*** range in the following sub-indicators:

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

- Healthcare providers generated a patient notification letter for pathology laboratory results within specified time frames for only one of 10 sampled patients (MIT 2.012, 10.0%). For eight patients, we found no evidence of a generated patient letter communicating pathology results. For the remaining one patient, the patient letter was missing key elements as required by policy.

Analysis of Performance Across Inspection Cycles

Figure 2. Diagnostic Services, Compliance Scores Across Cycles



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

Overall, the institution exceeded the 75.0 percent compliance threshold for diagnostic services, reaching 78.9 percent in Cycle 8. This performance over the past three cycles demonstrates significant steady improvement in this indicator from 44.7 percent in Cycle 6 and 58.9 percent in Cycle 7, indicating a successful commitment toward increasing compliance in this indicator.

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)	9	1	0	90.0%
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)	10	0	0	100%
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)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the health care provider generate the patient notification letter with all the required elements within the specified time frame? (2.006)	8	2	0	80.0%
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)	10	0	0	100%
Pathology: Did the health care provider generate the patient notification letter with all required elements within the specified time frame? (2.012)	1	9	0	10.0%
Overall percentage (MIT 2): **78.9%**				

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 and pathology results to the 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. Our clinicians further evaluated the healthcare leadership's ability to identify opportunities for improvement in the emergency medical response review process.

Case Review Ratings and Results Summary

In this cycle, case review found SATF provided sufficient emergency medical care. SATF staff responded promptly to medical emergencies and almost always provided immediate interventions, including timely activating EMS, initiating CPR promptly when required, and immediately transporting the patient to the TTA for further care. However, the OIG clinicians identified opportunities for improvement in nursing assessment, interventions, and documentation, as well as provider assessments. Additionally, SATF nursing and medical leadership frequently conducted clinical reviews of urgent and emergent events; however, they did not always identify the same deficiencies and opportunities for improvement the OIG clinicians identified. Considering all factors, the OIG rated this indicator ***adequate.***

Table 9. Emergency Services Case Review Results

Urgent or emergent events*	Deficiencies†	Significant deficiencies‡
29	32	11

* We reviewed 29 urgent or emergent events in 14 cases.

† Deficiencies occurred in cases 1, 2, 6–10, 15, 21, and 23.

‡ Significant deficiencies occurred in cases 1, 6, 7–10, 21, and 23.

Performed well

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

Performed satisfactorily with opportunities for improvement

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

- Emergency Medical Response

  SATF staff responded promptly to medical emergencies and generally provided immediate interventions, including timely activating EMS and transporting the patient to the TTA. The OIG clinicians did not find any trends with emergency medical response. However, we identified two significant findings:

  - In case 7, first responders activated a medical alarm for an unconscious patient with a suspected drug overdose. First responders initiated CPR and administered a dose of Narcan. Health care staff arrived at the scene and transported the patient to the TTA. However, staff did not activate EMS until 29 minutes later while in the TTA.

  - In case 21, first responders activated a medical alarm for a patient with "stroke symptoms." Health care staff arrived at the scene and transported the patient to TTA. EMS arrived to the TTA; however, the transportation team did not arrive to the TTA until 18 minutes after EMS, causing a delay in transport to the community hospital.

- Cardiopulmonary Resuscitation Quality[27]

  The OIG clinicians reviewed seven CPR cases and found the staff immediately initiated CPR and generally provided appropriate interventions. In one case, we identified a delay in applying the Automated External Defibrillator (AED) as follows:[28]

  - In case 10, staff activated a medical alarm for an unresponsive patient, then custody staff initiated CPR and notified EMS. The nurse arrived at the scene and transported the patient to the TTA. However, the nurses did not apply the AED until the patient arrived at the TTA nine minutes later.

- Nursing Performance in Assessments and Interventions[29]

  SATF nurses had mixed performance in providing emergency services. Nurses responded promptly to medical emergencies and consulted a provider when warranted.

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[27] CPR occurred in cases 3–7, 10, and 11. Deficiencies occurred in cases 6, 7, and 10. Significant deficiencies occurred in cases 7 and 10.

[28] Automated External Defibrillator (AED) is a portable device that can help restore a normal heart rhythm in a patient in cardiac arrest.

[29] Nursing performance deficiencies occurred in cases 1, 2, 6–10, and 23. Significant deficiencies occurred in case 1, 8–10, and 23.

However, we found opportunities for improvement in nursing assessments and interventions. The following are examples:

- In case 1, the patient walked into the clinic with complaints of chest pressure, headache, shortness of breath, and high blood pressure. The LVN notified the clinic RN of the patient's elevated blood pressure reading. The clinic RN assessed the patient but delayed consulting with the primary care provider (PCP) regarding the patient's symptoms for approximately 35 minutes from the time the patient arrived in the clinic, delaying necessary care. Once the clinic RN consulted with the PCP, the PCP ordered the patient to be transferred from the clinic to the TTA to facilitate further transfer to the community hospital. The PCP also ordered the RN standardized procedures for chest pain in addition to medication to decrease the blood pressure. The RNs utilized the RN standardized procedures; however, the RN did not administer aspirin and the first dose of nitroglycerin until over an hour after consulting with the PCP.[30] In addition, the RN did not administer the medication to lower the blood pressure until 47 minutes after receiving the order.

- In case 9, the RN assessed the patient in the TTA for grave disability and transferred the patient to a higher level of care for suspected pneumonia. The RN noted the patient had an elevated heart rate and appeared dehydrated and confused. The RN did not reassess the patient's elevated heart rate or vital signs until over an hour later.

- In case 10, custody staff activated a medical alarm for a patient with stomach pain. The nurse arrived at the patient's housing unit, and the patient complained of stomach pain with a history of chronic ulcerative colitis and blood with bowel movements.[31] The nurse obtained vital signs, educated the patient, and initiated a follow-up appointment with the provider. However, the nurse did not complete pain or abdominal assessments and left the patient in the housing unit instead of transferring the patient to the TTA for further evaluation.

- Nursing Performance in Documentation

  OIG clinicians found opportunities for improvement in nursing documentation. We identified patterns of incomplete documentation of nursing assessments. We also identified a pattern of timeline discrepancies related to sequences of emergency events;

[30] Nitroglycerin prevents and treats chest pain by relaxing the blood vessels.

[31] Ulcerative colitis is a chronic inflammatory bowel disease that causes inflammation and ulcers in the intestines.

however, these deficiencies generally did not affect the care provided to the patients. The following is a significant finding:

- In case 23, staff activated a medical alarm for the patient, who was found sitting on a bed with a weak appearance and had admitted to taking “spice.”[32] The nurse did not document the time of the medical alarm, the time medical staff was notified, the time the nurse arrived to the patient, or the time the nurse transferred the patient to the TTA. Additionally, the nurse did not document the time the patient was discharged from the TTA.

- Emergency Medical Response Review Committee[33]

OIG clinicians found SATF performed timely clinical reviews on emergency medical responses and unscheduled transports to a higher level of care. The Emergency Medical Response Review Committee (EMRRC) identified delays in custody transporting patients to the TTA or higher level of care, implemented monitoring interventions, and reported monthly to the committee. However, SATF did not always identify the same opportunities for improvement as the OIG, including the significant deficiency in which custody’s late arrival substantially delayed EMS departure to the community hospital.[34]

- Provider Performance

SATF providers performed acceptably with emergent or urgent care. Providers appropriately triaged patients, made good decisions with regard to treatments, and transferred patients to a higher level of care when medically indicated. OIG clinicians identified three deficiencies, one significant and two minor.[35] The minor deficiencies related to providers needing to improve on thorough evaluations and differential diagnoses. The following is the significant deficiency:

- In case 8, the TTA provider evaluated the patient, who complained to the nurse about chest pain. However, upon arrival to TTA, the patient clarified he was actually experiencing back pain. Despite this clarification, the nurse performed an EKG; however, we found no evidence the provider reviewed the EKG.[36]

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[32] “Spice” is a nickname for a variety of synthetic cannabinoid products that are laboratory-made chemicals designed to mimic the effects of the main psychoactive component in marijuana.

[33] EMR Clinical review deficiencies occurred in cases 1, 6–10, and 21. A significant deficiency occurred in case 21.

[34] SATF’s EMRRC did not identify the same opportunities for improvement as the OIG did in cases 1, 8, and 21. The significant deficiency occurred in case 21.

[35] Deficiencies occurred in cases 8 and 15. A significant deficiency occurred in case 8.

[36] 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.

Performed poorly, improvement needed

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

Clinician On-Site Inspection

During the on-site inspection, the OIG clinicians inspected the TTA and interviewed the TTA nursing staff. The TTA had three examination rooms. Two examination rooms were used for urgent or emergent care, and one was used for observation. Three RNs are assigned each shift during second and third watch, and two RNs are assigned during first watch. TTA nursing staff reported RNs rotate responsibility for responding to medical emergencies and experienced anywhere from three to fifteen emergency medical responses per day. One designated provider is available during business hours, and nurses contact the on-call providers after hours.

Photo 3. Treatment cart in the TTA. Photographed 3-18-2026.

The TTA staff did not conduct daily huddles, instead staff exchanged verbal reports between nurses during shift changes. In addition to emergencies, the TTA RNs described further responsibilities, such as processing patients returning from off-site specialty appointments and community hospitalizations. Upon a patient's return from an off-site medical appointment, nursing staff ensured the patient had discharge reports and recommendations, and they would contact the provider for immediate or urgent orders. The TTA staff scanned all discharge paperwork to care team shared folders, so providers and the teams both would have the information immediately. The medical records staff would also scan any discharge paperwork to the patient's EHRS. On the weekends, TTA staff was also responsible for triaging all sick call requests from the yards and completing all transfers and paroles, except for patients housed in a higher level of care, such as the correctional treatment center or mental health crisis beds. The TTA RNs we interviewed were pleasant and knowledgeable. One TTA RN was newer to state service, and another TTA RN had many years of experience within the institution. The TTA RNs reported good morale and great working relationships with leadership and custody staff.

Photo 4. Examination room in the TTA. Photographed 3-18-2026.

Photo 5. Emergency Response Vehicle (ERV). Photographed 3-18-2026.

Photo 6. Emergency Response Vehicle (ERV). Photographed 3-18-2026.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure nurses perform complete emergency assessments and thoroughly document their actions. Leadership should implement and monitor remedial measures as appropriate.

Emergency Services: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE

Compliance Score
(33.3%)

SATF performed poorly in the compliance component of 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

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

- Nursing staff inspected and inventoried disaster response bags within the required time frames for all applicable clinical areas (MIT 3.103, 100%).
- SATF 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%).

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

- The EMRRC did not review cases in a timely manner and failed to ensure incident packages included all required documents for any of the 12 sampled patients, resulting in a score of zero for this test (MIT 3.001, zero).
- Nursing staff did not inspect and inventory emergency medical response bags (EMRBs) and ensure they contained all essential items for any of the seven applicable clinical areas (MIT 3.101, zero). For all seven EMRBs, we found one or more of the following deficiencies: staff failed to ensure one EMRB's compartments were sealed and intact; staff had not inventoried the EMRBs when the seal tags were replaced (see Photo 7, right); and several EMRB daily glucometer quality control logs were either incomplete or inaccurate.

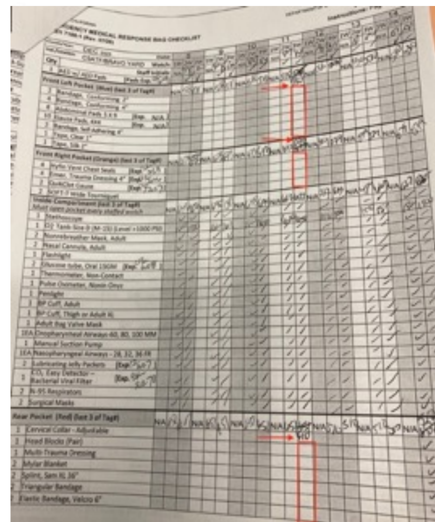


Photo 7. Incomplete EMRB inventory log. Photographed 2-2-2026.

- Nursing staff failed to inspect and inventory treatment carts within the required time frames for either of the two applicable clinical areas (MIT 3.102, zero). For both treatment carts, we found the following deficiencies: staff failed to maintain and complete a daily security check for the most recent 30 days; treatment carts' seal security check log documentation was incomplete because the log did not verify whether each seal was ***red*** (indicating the par level is complete) or ***yellow*** (indicating this supply must be replenished) (see Photo 8, left).

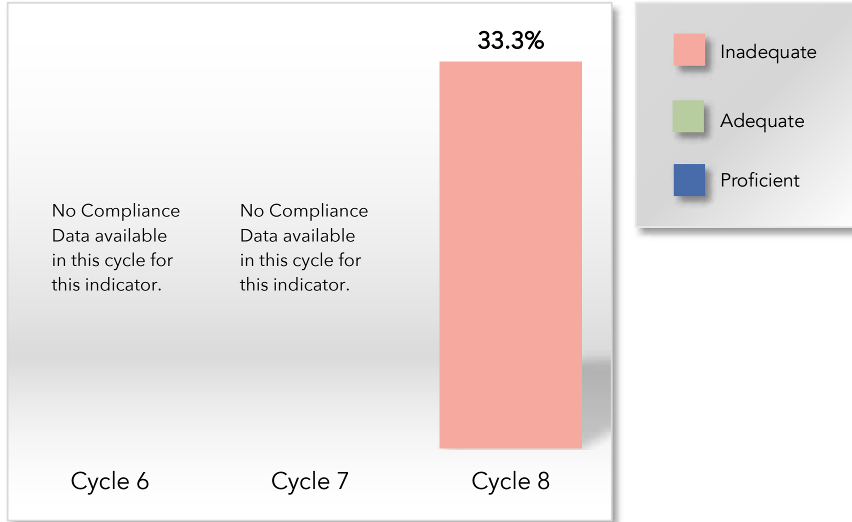
TREATMENT CART DAILY CHECK SHEET

Photo 8. Incomplete treatment cart seal security check log documentation.
Photographed 2-3-2026.

- The institution failed to conduct medical emergency response drills during each watch of the most recent quarter, resulting in a score of zero (MIT 3.104, zero). The emergency drill packets provided for two watches were documented as tabletop exercises, indicating staff did not complete actual mock code drills as required by CCHCS policy. Furthermore, one packet lacked documentation for the required time frames of all elements and contained inconsistent documentation.

Analysis of Performance Across Inspection Cycles

Figure 3. Emergency Services, Compliance Scores Across Cycles



Source: OIG SATF 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 a significant need for improvement. Specifically, the institution did not meet the 75.0-percent compliance threshold for emergency services readiness and performance evaluation, reaching only 33.3 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, regression in MITs 3.001, 3.101, and 3.102, and continuing poor scores in MIT 3.104.

Table 10. Changed MIT Numbers Over Cycles 6, 7, and 8

Cycle 8 MIT Test Number	Cycle 6 Scores	Cycle 7 Scores	Cycle 8 Scores
MIT 3.001	91.7%	25.0%	0.0%
MIT 3.101 & 3.102	30.0%	10.0%	MIT 3.101 0.0% MIT 3.102 0.0%
MIT 3.104	0.0%	0.0%	0.0%
MIT 3.105	50.0%	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

Compliance Questions	Scored Answer			
	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)	0	12	0	0
Clinical areas: Are emergency medical response bags inspected and inventoried within required time frames, and do they contain essential items? (3.101)	0	7	2	0
Clinical areas: Are treatment carts inspected and inventoried within required time frames? (3.102)	0	2	7	0
Clinical areas: Are disaster response bags inspected and inventoried within required time frames? (3.103)	1	0	8	100%
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): **33.3%**				

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

Compliance Recommendations

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

Health Information Management

In this indicator, OIG inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. Our inspectors examined whether the institution retrieved and scanned critical health information (progress notes, diagnostic reports, specialist reports, and hospital discharge reports) into the medical record in a timely manner. Our inspectors also tested whether 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.

Case Review Ratings and Results Summary

In this cycle, case review found SATF performed satisfactorily in health information management (HIM). SATF staff always retrieved hospital records and scanned emergent records timely. They also performed well with scanning medical documents. However, we identified instances of staff scanning specialty reports late. Additionally, we found providers mostly endorsed results timely but frequently sent incomplete patient notification letters or did not send the letters at all. Taking all factors into consideration, the OIG rated the case review component of this indicator ***adequate***.

Table 12. HIM Case Review Results

Events*	Deficiencies†	Significant Deficiencies‡
818	100	11

* The OIG reviewed 818 events.

† Deficiencies occurred in cases 1,2, 7–20, 22, 24, 25, and 32.

‡ Significant deficiencies occurred in case 11, 14, 17, 20, 22, and 24.

Performed Well

OIG clinicians found SATF performed well in the following areas:

- Hospital Reports[37]
- Urgent and Emergent Records[38]
- Scanning Performance[39]

Performed Satisfactorily, with Opportunities for Improvement

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

- Specialty Reports

  OIG clinicians identified eight deficiencies related to specialty report information management.[40] Four related to providers untimely endorsing reports, three related to staff scanning reports late into EHRS, and one involved staff not sending a report to the provider for endorsement. The following is an example:

  - In case 24, the provider endorsed a urology procedure report eight days late.

Performed Poorly, improvement needed

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

- Diagnostic Reports

  SATF performed poorly in managing the results of diagnostic tests. OIG clinicians identified 84 deficiencies related to diagnostic information management. Of those, 70 related to incomplete or unsent patient test result notification letters, and 12 related to untimely endorsement of laboratory and imaging results, six of which were significant.[41] Please refer to the **Diagnostics** indicator for more information. The following are examples:

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

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

[39] A minor deficiency occurred in case 7 related to an incorrect time of a scanned EKG report. A minor deficiency in case 9 related to a misdated scanned EKG report.

[40] Specialty report health information management deficiencies occurred in cases 11, 12, 14, and 24.

[41] Minor test result letter deficiencies occurred in cases 1, 2, 8, 9, 11–17, 19, 20, 22, 25, and 32. Deficiencies related to untimely endorsements occurred in cases 14, 17, 18, and 22. Significant untimely endorsement deficiencies occurred in cases 14, 17, and 22.

- In case 2, the patient underwent x-rays of the cervical spine to evaluate for pain. However, the provider did not send the patient a result notification letter.
- In case 14, the provider endorsed results of an INR laboratory test for a patient on warfarin nine days late.[42]

Clinician On-Site Inspection

The OIG clinicians met with HIM leadership and staff, and we inspected the HIM department. Leadership reported, at the time of the inspection, the HIM department had seven health records technicians (HRTs), one HRT supervisor, and four office assistants (OAs), with one working out of class. During the review period of July 2025 through January 5, 2026, the HIM department had one vacant HRT position for three months. Leadership reported no scanning backlog during our on-site inspection.

Leadership stated HIM historically maintained a log of received and scanned hospital reports. However, SATF implemented a new system to track both hospital reports and specialty services. Through this new system, leadership reported HIM staff collects off-site specialty services and hospital reports that require scanning each weekday. HIM staff also collects any weekend or overnight hospital or emergency reports when returning the next morning or on Mondays. HIM staff reviews the census of patient transfers to higher levels of care, checks for any missing reports, and scans the reports into the EHRS. For any missing documents, HIM staff contacts SATF's off-site RN, and the off-site RN retrieves the missing reports online (if available) or contacts the hospital and then forwards the reports to HIM for scanning. HIM staff then forwards the reports to the providers for review and endorsement. For any urgent recommendations from specialty services or hospital returns, nursing staff also emails or contacts a SATF provider, depending upon the urgency of the recommendations.

For specialty services, leadership stated the on-site optometry, ophthalmology, audiology, orthotics, and gastroenterology specialists complete reports the same day, while podiatry specialists complete their reports within three days. Physical therapy and dietary specialists enter their reports directly into the EHRS, and they send an email to the patient's provider for any new recommendations. Leadership also informed us the new CCHCS policy regarding providers entering orders for outstanding pathology reports upon review of hospital and specialty records worked well and decreased delayed receipt of pathology reports.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

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[42] INR, international normalized ratio, is a laboratory test to measure the body's blood clotting. This test is used to monitor the effectiveness of blood-thinning medications such as warfarin.

Health Information Management: Compliance Ratings and Results Summary

In this indicator, SATF performed satisfactorily with some opportunities for continued growth and refinement 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 ***adequate.***

Compliance Testing Results

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

- The institution achieved a perfect compliance score for the timely integration of health care services request forms (CDCR Form 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 exhibited proficiency in ensuring the providers reviewed and endorsed community hospital discharge reports within five calendar days of discharge for 23 of 25 sampled patients (MIT 4.005, 92.0%). For two patients, the providers reviewed the report one day late.

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

- The institution demonstrated good operational performance, ensuring community hospital discharge documents were scanned into the patients' EHRS within required time frames for 16 of 20 sampled patients (MIT 4.003, 80.0%). For four patients, staff scanned the reports between one and three days late.

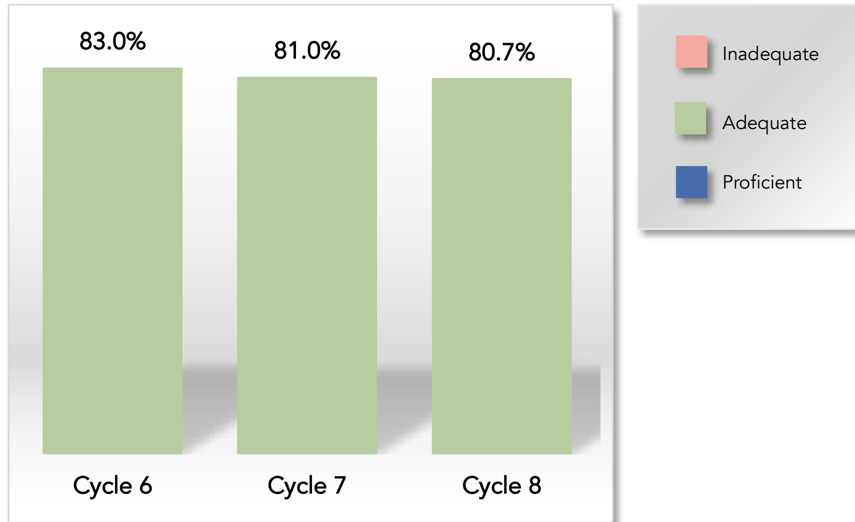
SATF performed in the ***inadequate*** range in the following sub-indicators:

- The institution exhibited a need for improvement in ensuring staff scanned specialty notes into the patients' EHRS in accordance with established timelines. Staff met required scanning timelines for 19 of 30 patients we tested (MIT 4.002, 63.3%). For 11 patients, staff scanned the specialty reports between one and 18 days late.

- The institution properly labeled and scanned records into the patients' records for 17 of 25 patients (MIT 4.004, 68.0%). For eight patients, the documents were either missing or mislabeled.

Analysis of Performance Across Inspection Cycles

Figure 4. Health Information Management, Compliance Scores Across Cycles



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

In Cycle 8, SATF's performance met the 75.0-percent compliance threshold for health information management (HIM), reaching 80.7 percent in Cycle 8. While the rating remains adequate, this score follows slightly higher performance results of 83.0 percent in Cycle 6 and 81.0 percent in Cycle 7. The current score represents a minor regression from previous cycles, indicating the institution's performance is trending closer to 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	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	19	11	15	63.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	16	4	5	80.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	17	8	0	68.0%
For patients discharged from a community hospital: Did a provider review and endorse the report within five calendar days of discharge? (4.005)	23	2	0	92.0%
Overall percentage (MIT 4): **80.7%**				

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 scanning medical records and labeling medical records in the correct patient's file. Leadership should implement and monitor remedial measures as appropriate.
- Health care leadership should develop, implement, and monitor strategies to ensure staff timely retrieve and scan all specialty reports within the required time frames. 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
(79.6%)

SATF met the required benchmarks acceptably during this inspection cycle. Based on the overall compliance score result of 79.6 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- The institution demonstrated excellence in ensuring staff consistently updated the corresponding cleaning logs for nine of 10 clinics (MIT 5.101.3, 90.0%). In one clinic, the cleaning log was missing documentation, confirming the area was cleaned.

- The institution met all performance standards for ensuring reusable invasive medical equipment was properly sterilized or disinfected as warranted for all applicable sampled clinics (MIT 5.102.1, 100%).

- The institution achieved perfect performance in ensuring reusable non-invasive medical equipment was properly disinfected as warranted for all six applicable clinical health care areas (MIT 5.102.2, 100%).
- The institution attained perfect performance in ensuring clinical health care areas controlled exposure to blood-borne pathogens and contaminated waste for all nine applicable clinics (MIT 5.105, 100%).
- The institution's medical warehouse delivered exceptional performance in ensuring the medical supply management process adequately supported 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 were conducive to providing medical services for all 10 clinics (MIT 5.109.1, 100%, and MIT 5.109.2, 100%).
- The institution upheld superior performance in ensuring the clinic exam rooms have adequate space and remained free of clutter to provide medical services for all 10 clinics (MIT 5.110.1, 100%, and MIT 5.110.2, 100%). Furthermore, all 10 clinic examination rooms were equipped with working computer stations, well-maintained furniture, and accessible medical equipment (MIT 5.110.3, 100%).

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

- The institution demonstrated very good performance in maintaining a clean and sanitary environment for eight of 10 clinical health care areas (MIT 5.101.2, 80.0%). In two clinics, inspectors identified an uncleaned floor and cabinet (see Photo 9, below left).

Photo 9. Floor was found soiled. Photographed 2-3-2026.

Photo 10. Exam room lacked adequate visual privacy. Photographed 2-3-2026.

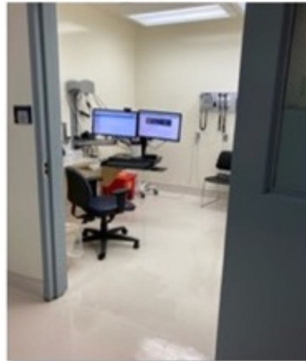


Photo 11. Clinical staff left computer screen unlocked. Photographed 2-3-2026.

- Eight of 10 clinics ensured examination rooms allowed for privacy and confidentiality when providing medical services (MIT 5.110.4, 80.0%). In two clinics, we found one or more of the following deficiencies: the examination rooms lacked adequate provisions for visual privacy; confidential medical records were not shredded regularly and were easily accessible to unauthorized persons (see Photo 10, above left); additionally, clinical staff left computer screens unlocked, exposing active data to unauthorized viewing (see Photo 11, above right).

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

- Two of 10 clinics ensured clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies (MIT 5.103, 20.0%). In eight clinics, the patient restrooms and examination rooms lacked antiseptic soap and disposable towels.

- Only two of six medical staff observed ensured adherence to universal hand hygiene precaution, in which staff follows proper handwashing protocols (MIT 5.104, 33.3%). In four clinics, clinicians did not wash or sanitize their hands before each subsequent regloving, or before and after physically touching the patient.

Photo 12. Medical supplies stored directly on the floor. Photographed 2-3-2026.

- Six of 10 clinics ensured adequate management and storage of bulk medical supplies (MIT 5.107, 60.0%). Specific deficiencies for four clinics included general disorganization, medical supplies stored directly on the floor (see Photo 12, right), storage of supplies beyond manufacturing guidelines (see Photo 13, next page left), and improper co-storage of long-term food in clinic area (see Photo 14, next page right).

Photo 14. Expired medical supplies.
Photographed 2-3-2026.

Photo 15. Improper co-storage of long-term food.
Photographed 2-3-2026.

- Only one of 10 clinics ensured common areas and examination rooms were equipped with essential core medical equipment and supplies (MIT 5.108.2, 10.0%). In nine 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 15, right); equipment was missing the current calibration sticker; and several clinic glucometer quality control logs were incomplete.

Photo 13. Examination table missing disposable paper.
Photographed 2-2-2026.

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 SATF 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.

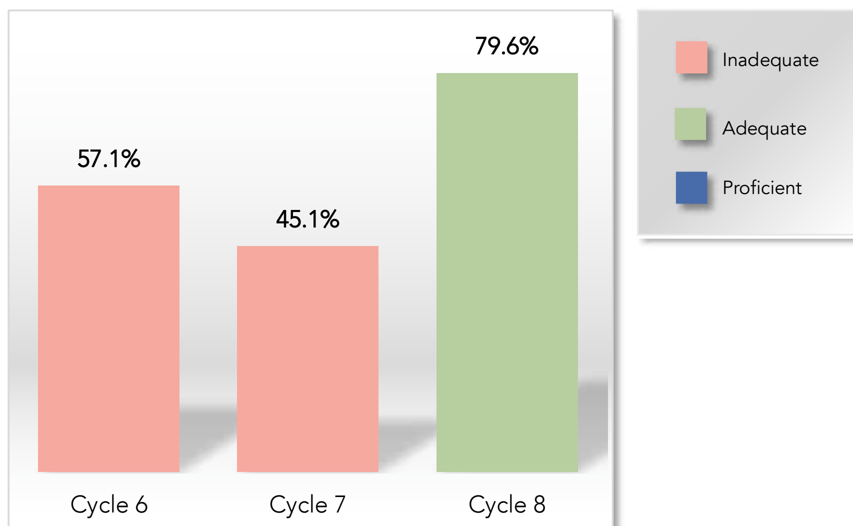
- Patient waiting areas: We inspected indoor patient waiting areas. Health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 16, right). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.

- 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).

Photo 16. Sufficient patient waiting area. Photographed 2-2-2026.

Analysis of Performance Across Inspection Cycles

Figure 5. Health Care Environment, Compliance Scores Across Cycles



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

In Cycle 8, SATF 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 79.6 percent in Cycle 8. This rating demonstrates significant improvement following previous inadequate ratings of 57.1 percent in Cycle 6 and 45.1 percent in Cycle 7, indicating a strong commitment to progress in this area.

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	10	N/A
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101.2)	8	2	0	80.0%
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)	9	1	0	90.0%
Infection control: Do clinical health care areas ensure that reusable invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.1)	1	0	9	100%
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	4	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	2	8	0	20.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	4	4	33.3%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	0	1	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)	6	4	0	60.0%
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	10	N/A
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108.2)	1	9	0	10.0%
Clinical areas: Are the environments in the common clinical areas conducive to providing medical services? (5.109.1)	9	0	1	100%
Clinical areas: Are the environments in the common non-clinical areas conducive to providing medical services? (5.109.2)	10	0	0	100%
Clinical areas: Do the clinic exam rooms have adequate space to provide medical services? (5.110.1)	10	0	0	100%
Clinical areas: Are the clinic exam rooms free of clutter and conducive to providing medical services? (5.110.2)	10	0	0	100%
Clinical areas: Do clinic exam rooms have working computer stations and well-maintained furniture and accessible medical equipment? (5.110.3)	10	0	0	100%
Clinical areas: Do clinic exam rooms allow for privacy and confidentiality when providing medical services? (5.110.4)	8	2	0	80.0%
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): **79.6%**				

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 experienced 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 SATF performed sufficiently in the transfer process. The nurses screened patients appropriately for patients who transferred into the institution, and nurse and provider appointments occurred timely. When patients returned from a hospitalization, the nurses generally performed appropriate assessments. However, we identified opportunities for improvement in medication continuity for patients transferring into the institution and patients who returned from a hospitalization or emergency room encounter. Additionally, we found SATF needs improvement for patients who transferred out of the institution because nurses did not always ensure transfer requirements were met and often did not communicate pending specialty appointments to the receiving institution. Considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Table 15. Transfers Case Review Results

Transfer Events*	Deficiencies†	Significant Deficiencies‡
63	21	9

* The OIG clinicians reviewed 63 events in 19 cases in which patients transferred into or out of the institution and 14 events in which patients returned from an off-site hospital or emergency room.

† Deficiencies occurred in cases 1, 2, 8–10, 21–23, and 28–32.

‡ Significant deficiencies occurred in cases 1, 2, 10, 22, 23, 30, and 32.

Performed Well

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

Performed Satisfactorily with Opportunities for Improvement

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

- Transfers In[43]

  OIG clinicians found the receiving and release (R&R) nurses screened patients appropriately and requested provider appointments within the required time frame. However, we found opportunities for improvement in medication management. The following is an example:

  - In case 10, the patient transferred to SATF and did not receive their next scheduled dose of their chronic care medications, including medications to treat high blood pressure, blood clots, abnormal thyroid levels, and fluid retention.

- Hospital Returns[44]

  OIG clinicians found nurses generally performed appropriate assessments and interventions for patients returning from a hospitalization and mostly reviewed hospital recommendations. However, we found SATF had opportunities for improvement in ensuring thorough nursing assessments after patients returned from the community

[43] OIG clinicians reviewed 17 transfer-in events in cases 2, 9–11, and 26–28. Transfer-in deficiencies occurred in cases 2, 10, and 28. A significant deficiency occurred in case 2.

[44] OIG clinicians reviewed 14 hospital return events in cases 1, 2, 8–10, 21–23, and 32. Hospital return deficiencies occurred in cases 1, 2, and 8. Significant deficiencies both occurred in case 1.

hospital and found nursing needed improvement in ensuring medication continuity. The following examples are significant findings:

- In case 1, the patient returned from the hospital after being evaluated for chest pain, headache, shortness of breath, and elevated blood pressure. However, we found no nursing face-to face assessment completed for the patient upon hospital return. During the case review inspection, the institution agreed with the deficiency.

- In case 10, the patient returned from the hospital, and the provider ordered new medication to treat ulcerative colitis, as recommended by the hospital. However, the patient did not receive the medication as ordered. During the case review inspection, the institution agreed with the deficiency.

Performed Poorly, Improvement Needed

OIG clinicians found SATF performed poorly in the following:

- Transfer Out[45]

  OIG clinicians found nurses did not consistently ensure all transfer requirements were met for patient transfers out of the institution. We also identified a pattern in which nurses did not communicate pending specialty appointments to the receiving institution. Additionally, we found patients did not always transfer with their prescribed medications. The following are examples:

  - In case 2, the correctional treatment center (CTC) patient did not transfer with their essential medications, including those to treat high blood pressure, high cholesterol, acid reflux, blood clots, mental health, asthma, and an abnormal prostate. During the case review inspection, the institution agreed with the deficiency.

  - In case 30, the R&R nurse screened this patient, who transferred to another institution. The patient had testicular cancer with an established plan to start chemotherapy the following week. However, the nurse did not identify the patient's plan of care to start chemotherapy, document the patient had a port-a-cath, or contact the provider to determine whether a medical hold was

[45] OIG clinicians reviewed 11 transfer-out events in cases 2, 22, and 29–32. Transfer-out deficiencies occurred in each case. Significant deficiencies occurred in cases 2, 22, 30, and 32.

needed.[46] Additionally, the nurse did not document or communicate a handoff to the receiving institution to include two pending referrals to chemotherapy and oncology. Fortunately, the receiving institution identified the pending chemotherapy appointments and transferred the patient back to SATF two days later. During the case review inspection, the institution agreed with the deficiency.

- In case 32, the patient transferred from the CTC to another institution. However, the nurse did not perform a COVID-19 screening and did not send the patient's rescue medications to treat asthma or chest pain with the patient. Additionally, the nurse did not communicate the patient's follow-up kidney specialist referral to the receiving institution.

Clinician On-Site Inspection

Our clinicians inspected the R&R unit and interviewed the day shift R&R RN and OT. The RN was knowledgeable about the transfer process and stated an average of 60 patients transfer into SATF weekly, and an average of 30 patients transfer out. The R&R RN shared, when patients transferred in, staff communicated any pending specialty appointments to the primary care team and the specialty department. When patients transferred out, staff documented any pending specialty appointments on the transfer form and notified the receiving institution through the EHRS message pool. The R&R OT assisted with completing transfer packets for patients transferring out of the institution. Additionally, the R&R OT maintained a log to monitor the new arrivals to the institution, which the OTs used daily to verify the nurses placed all required orders and to notify the OTs on the yards of the new arrivals.

Photo 17. Receiving & Release examination room. Photographed 3-18-2026.

Case Review Recommendations

- Nursing leadership should develop, implement, and monitor strategies to ensure the receiving and release (R&R) nursing staff thoroughly complete the transfer-out screening process with attention to medication continuity and pending specialty referrals.

[46] A port-a-cath is a device that is placed under the skin in the right side of the chest and is attached to a catheter. Medical personnel use this device to give intravenous fluids, chemotherapy, blood, and drugs.

Transfers: Compliance Ratings and Results Summary

SATF demonstrated very good performance for this indicator. Based on the overall compliance score result of 88.6 percent, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Testing Results

SATF 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 23 of 25 patients (MIT 6.001, 92.0%). For two patients, nursing staff did not document the patient's blood pressure and blood sugar level in the initial health screening forms.

- Nursing staff showed proficiency in completing the assessment and disposition sections of the initial health screening form for all 25 applicable sampled patients (MIT 6.002, 100%).

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

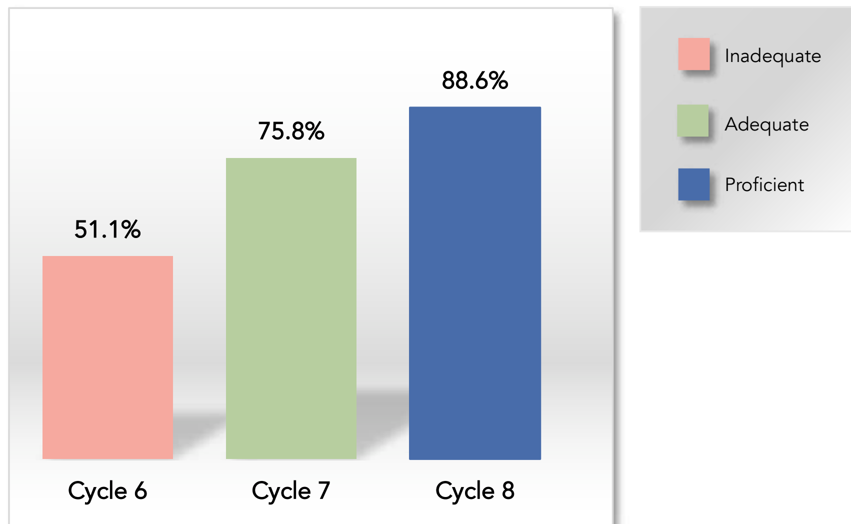
- Nursing staff ensured medications were administered or delivered without interruption for 15 of 24 applicable sampled patients (MIT 6.003, 62.5%). For nine patients, we found one or more of the following deficiencies: incomplete documentation of the patient's reason for refusing medication, incomplete documentation of the patient's reason for not presenting to the medication line, or the record contained no evidence whether patients refused or received medications.

Compliance On-Site Inspection and Discussion

- The institution demonstrated proficiency in ensuring medication transfer packages included all required durable medical equipment along with the corresponding transfer packet required documents for both applicable patients (MIT 6.101, 100%).

Analysis of Performance Across Inspection Cycles

Figure 6. Transfers, Compliance Scores Across Cycles



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

In Cycle 8, SATF performed above established standards for Transfers, successfully exceeding the requirements for this cycle. The institution surpassed the 75.0-percent compliance threshold for the Transfers indicator, reaching 88.6 percent in Cycle 8. SATF's performance over the past three cycles demonstrates continual significant improvement from 51.1 percent in Cycle 6 to 75.8 percent in Cycle 7, to now performing in the proficient range in Cycle 8. This steady rise in scores is indicative of an outstanding commitment to improvement.

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)	23	2	0	92.0%
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)	25	0	0	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)	19	9	1	62.5%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	2	0	0	100%
Overall percentage (MIT 6): **88.6%**				

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 SATF overall needed improvement in medication management. OIG clinicians found opportunities for improvement in medication continuity for patients who transferred into or out of the institution, patients in specialized medical housing, and patients receiving newly prescribed medications. Specifically, we identified lapses in medication continuity throughout the institution, which led to multiple cases in which patients did not receive chronic care medications for a month or more. We also identified a similar trend of lapses in medication continuity for patients returning from hospitalizations. In addition, nursing staff often erroneously entered incorrect information when documenting in the medication administration record (MAR), which contributed to the patients not receiving medications timely. Considering all factors, the OIG rated the case review component of this indicator ***inadequate.***

Table 17. Medication Management Case Review results

Medication Events*	Deficiencies†	Significant Deficiencies‡
131	54	26

* The OIG clinicians reviewed 131 events in 27 cases related to medications.

† Deficiencies occurred in cases 1, 2, 10–13, 15, 17–19, 21–25, 28, 31, and 32.

‡ Significant deficiencies occurred in cases 1, 2, 10–13, 15, 17, 23, and 24.

Performed Well

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

Performed Satisfactorily with Opportunities for Improvement

Our clinicians found SATF performed satisfactorily, with opportunities for improvement in the following:

- Transfer Medications[47]

  SATF nurses usually ensured patients received their medications when patients transferred in or out of the institution. However, our clinicians identified a trend in which, when patients transferred into the institution, they did not always receive the next scheduled dose or received an incorrect dose of their medication. Below is an example:

  - In case 28, the newly arrived patient was scheduled to receive the next dose of medication for nerve pain. The nurse erroneously documented "Not Done: Task Duplication," despite the patient not having received the dose, which resulted in the patient missing this dose of medication.[48]

- Specialized Medication Housing Medications[49]

  OIG clinicians found most patients received medication in the specialized medical housing unit timely. However, we did identify an opportunity for improvement in proper documentation. The following is an example:

  - In case 32, on two separate occasions, the diabetic patient did not receive the scheduled dose of regular insulin. In addition, on one of the dates the nurse erroneously documented "Not Done: Task Duplication." As a result, staff did not administer insulin to the patient that day.

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[47] Transfer medication deficiencies occurred in cases 2, 10, 28, and 31. A significant deficiency occurred in case 2.

[48] "Task Duplication" is written in a medical record to explain why a medication was not administered due to it having been already administered or because a valid order previously existed for the same medication at the same time.

[49] Specialized Medical Housing medication deficiencies, none of which were significant, occurred in cases 21, 22, and 32.

- Newly Prescribed Medication

  OIG clinicians found patients frequently received newly prescribed medications timely. However, we identified opportunities in preventing lapses in medication continuity. The following are examples:

  - In case 10, the provider ordered a steroid medication, prednisone, for seven days for the patient returning from the hospital to treat severe colon inflammation. The patient received the medication seven days late.

  - In case 12, the patient was scheduled to receive a newly prescribed blood thinner medication. However, the nurse incorrectly documented "Not Done: overdue task. Clearing backlog." Therefore, the patient missed one dose of the medication.

Performed Poorly, Improvement Needed

OIG clinicians found SATF performed poorly in the following:

- Chronic Medication Continuity

  SATF performed poorly with ensuring medication continuity for patients with chronic conditions. Our clinicians reviewed 27 cases in which staff administered chronic care medications, and we identified medication lapses in 16 cases, nine of which were significant.[50] Our clinicians identified the following trends: patients did not receive monthly prescriptions for medications or nurses inconsistently documented on the patients' MARs. Below are examples:

  - In cases 1, 2, 10, 11, 12, 19, 22, 28, 32, nurses incorrectly documented in the MAR "clearing a task, schedule conflict, task duplication," or "medication not available," each of which caused patients not to receive their medications as prescribed.

  - In case 10, a provider prescribed medications to treat high blood pressure and thyroid disease for the patient with a history of multiple chronic conditions. The day after the provider ordered the medication, the nurse erroneously documented on the patient's MAR "Not Done: Task Duplication." As a result, the patient did not receive the prescribed medications until approximately two months later.

  - In case 11, the patient did not receive the chronic care medication, Truvada, a medication to treat HIV, for August and September 2025.

[50] Chronic care medication deficiencies occurred in cases 1, 2, 10-13, 15, 17-19, 21-25, and 32. Significant deficiencies occurred in cases 1, 10-13, 15, 17, 23, and 24.

  - In case 12, on one date, the nurse erroneously administered double the normal dose of a prescribed blood thinner, which increased the patient's risk for bleeding. On a separate date, the patient did not receive one dose of the prescribed blood thinner medication.

  - In case 13, the patient was scheduled to receive an automatic refill for the chronic medication for diabetes management. The patient did not receive the medication until 15 days later, after the provider increased the patient's dose and wrote a new medication order.

  - In case 17, the patient did not receive the multiple chronic care medications to treat high blood pressure, amlodipine and lisinopril, for two months.

- Hospital Discharge Medication

  Our clinicians identified a trend of lapses in medication continuity when patients returned to the institution from hospitalization or emergency room evaluations. The following are examples:

  - In case 21, the patient returned from hospitalization with a stroke discharge diagnosis. The discharge summary recommendations included an increase in the patient's cholesterol lowering medication. However, the medication was not ordered and the patient continued receiving the medication at the previously prescribed dose.

  - In case 24, the patient returned from hospitalization with a discharge diagnosis of left ankle cellulitis and recommendations to start the following antibiotics, ciprofloxacin and Bactrim for 10 days. However, the patient did not receive the scheduled morning dose of the antibiotics the day after returning from the hospital.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians inspected the medication administration areas in B, C, D, and E yards. We interviewed medication management LVNs. Most medication nurses were knowledgeable about the medication process. LVNs in C and D yards did not attend the morning huddles due to administering medications at the time huddles were conducted. However, nurses reported they would notify the provider via phone or electronic messaging if they encountered medication issues, including expired medications.

While SATF struggled with medication management throughout the institution, it was especially noted on C yard. C yard LVNs reported many challenges with medication management, including frequent modified or lockdown programs, as well as a diverse patient population with greater challenges all housed within the same yard and often in the same buildings.[51] In addition, C yard consisted of eight buildings and thus had the largest population with the highest number of patients requiring medication administration, requiring six LVNs to be assigned to C yard daily. During the on-site inspection, the LVNs reported medication pass was relocated from the C yard clinic medication window to individual building podium passes in November 2025 to minimize interruption from modified and lockdown programs. The pharmacist in charge (PIC) and the chief nurse executive (CNE) also informed our clinicians that plans were in place to permanently establish locked medication rooms in each of the eight buildings in C yard, some of which would also include an Omnicell, to decrease medication pass times, medication errors, and the amount of physical strain on staff from pushing the large medication carts to the buildings several times per day.

Photo 19. C yard medication distribution room. Photographed 3-17-2026.

Photo 18. E yard medication distribution room. Photographed 3-18-2026.

[51] A "modified program" or "lockdown program" is a temporary change to regular prison operations. CDCR uses this status to protect safety and security when the institution experiences an elevated threat or ongoing investigations such as after violence, contraband discoveries, or other serious incidents.

The B, D, and E Yard medication areas were clean, well-organized, and had adequate space for the medication nurses. Patients received medications at the yard clinic medication windows.

During our on-site inspection, OIG clinicians interviewed the PIC and CNE and discussed the lapses in medication management we identified during our clinical review, particularly with chronic care medications. OIG clinicians inquired about chronic care medications that were ordered as "request refill" and how they tracked medication compliance for keep-on-person (KOP) pickup.[52] The PIC reported few chronic care medications were ordered with this special request; however, all chronic care medications, regardless of this "request refill" designation, were routinely filled and sent to the medication distribution room for the patient to pick up or sign for refusal. The only medications not automatically refilled were medications ordered on an "as needed" basis, which would require the patient to submit a refill request. Both the PIC and CNE reported they were not aware of chronic care medications being ordered as both auto refill and request refill. OIG clinicians also discussed medication management documentation inconsistencies. Nursing leadership indicated these appeared to be related to various reasons, such as modified or lockdown programs, inexperienced nursing staff, large workload, vacancies, and some "human error." Nursing leadership stated SATF would provide training to staff to ensure proper documentation.

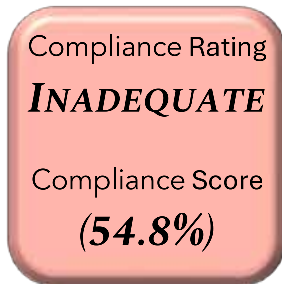
Case Review Recommendations

- Health care leadership should determine the root causes of challenges for inconsistent medication continuity for chronic care, newly prescribed, transfers, hospital discharge, and specialized medical housing medications. Leadership should implement and monitor remedial measures as appropriate.

- Nursing leadership should determine the causes of erroneous documentation on the patient's medication administration record; leadership should implement remedial measures as appropriate.

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

Medication Management: Compliance Ratings and Results Summary



SATF presented substantial opportunities for improvement in this indicator. Based on the overall compliance score result of 54.8 percent, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

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

- The institution showed proficiency in making new order prescription medications available to patients within the required time frames for 16 of 18 applicable sampled patients (MIT 7.002.1, 88.9%). For two patients, the pharmacy did not make newly ordered medications available to the patients within the required time frame.
- The institution adequately stored and secured narcotic medications in all nine applicable clinic and medication line locations (MIT 7.101, 100%).
- Staff successfully stored valid, unexpired medications in eight of nine medication line locations (MIT 7.104, 88.9%). For one location, nursing staff did not label multi-dose medication as required by policy.
- Staff in all six applicable medication preparation and administration areas showed appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 100%).
- SATF pharmacy staff followed general security, organization, and cleanliness management protocols in its main pharmacy (MIT 7.108, 100%).

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

- Staff kept medications protected from physical, chemical, and temperature contamination in seven of nine applicable clinic and medication line locations (MIT 7.103, 77.8%). In two locations, medication refrigerators were unsanitary (see Photo 20, right).

Photo 20. Medication refrigerator unsanitary. Photographed 2-2-2026.

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

- Only three of 17 applicable patient samples received chronic care medications within required time frames (MIT 7.001, 17.6%). 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 "keep on person" (KOP) medications were not issued within policy time frames.

- The institution administered or issued new order prescription medications within required time frames for 15 of 25 patients (MIT 7.002.2, 60.0%). In 10 patients, we found one or more of the following deficiencies: nursing staff did not administer direct observation therapy (DOT) and nurse administered (NA) medications within the provider's order; staff did not document the patient's stated reason for refusing medication or reason for not presenting to the medication line; and staff did not issue KOP medications within policy time frame requirements.

- The provider ordered post-hospitalization medication orders within the required time frame for 14 of 20 sampled patients (MIT 7.003.1, 70.0%). For six patients, the provider did not timely order the medications within eight hours of the patient's return from the hospital, as required by policy.

- The institution's pharmacy made available post-hospitalization medication orders within the required time frame for only eight of 18 applicable sampled patients (MIT 7.003.2, 44.4%). For 10 patients, the pharmacy did not timely fill and dispense medications as ordered.

- The institution administered or issued post-hospitalization medication orders within the required time frames for 10 of 20 applicable sampled patients (MIT 7.003.3, 50.0%). For 10 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 for patients transferring within the institution for 14 of 25 patients (MIT 7.005, 56.0%). For 11 patients, we found one or more of the following deficiencies: incomplete documentation of the patient's reason for refusing medication, incomplete documentation of the patient's reason for not presenting to the medication line, or the record contained no evidence showing whether the patient refused or received medication.

- SATF appropriately stored and secured non-narcotic medications in six of nine clinic and medication line locations (MIT 7.102, 66.7%). In three locations, we found one or more of the following deficiencies: nurses did not maintain unissued medication in its original labeled packing (see Photo 21, below left), and patient medication was found with expired pharmacy label (see Photo 22, below right).

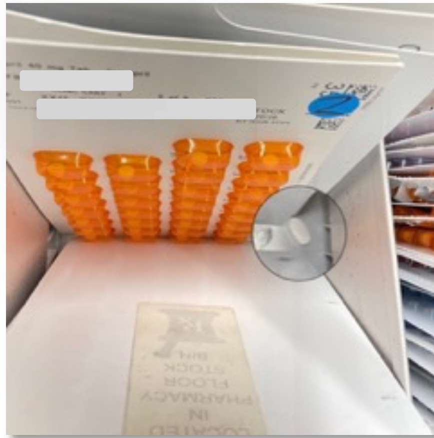


Photo 21. Nurses did not maintain unissued medication in its original labeled packing. Photographed 2-2-2026.

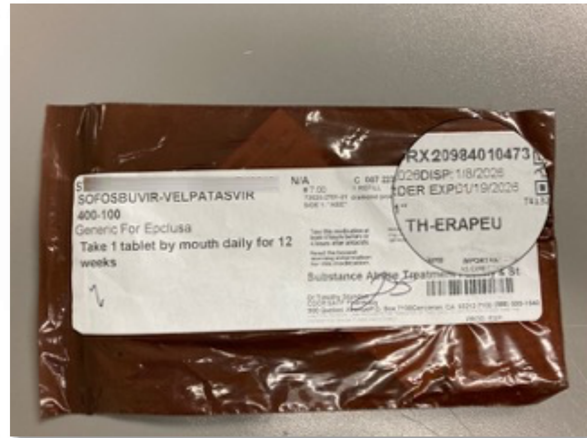


Photo 22. Expired pharmacy label. Photographed 2-3-2026.

- Nurses exercised proper hand hygiene and contamination control protocols in three of six applicable locations (MIT 7.105, 50.0%). In three 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 four of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 66.7%). In two locations, medication nurses did not always ensure patients swallowed DOT medications.

- SATF failed to properly store nonrefrigerated medication in the pharmacy location (MIT 7.109, zero). Inspectors found medication packaging was compromised (see Photo 23, right).

Photo 23. Compromised medication packaging. Photographed 2-3-2026.

- The institution failed to properly store refrigerated or frozen medications in its main pharmacy (MIT 7.110, zero). Inspectors found refrigerated medication storage area uncleaned (see Photo 24, below left).

- 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) (see Photo 25, below right).

- We examined 25 medication error reports. For 24 reports, we found one or more the

Photo 24. Pharmacy medication storage uncleaned. Photographed 2-3-2026.

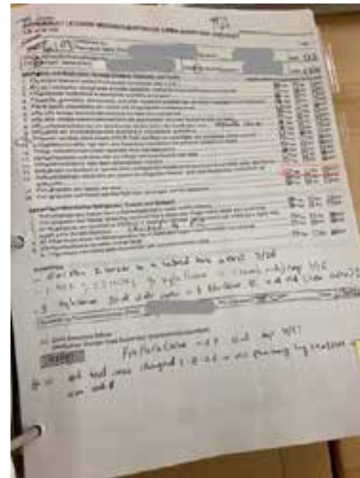


Photo 25. CDCR 7477-B with incomplete checklist. Photographed 2-4-2026.

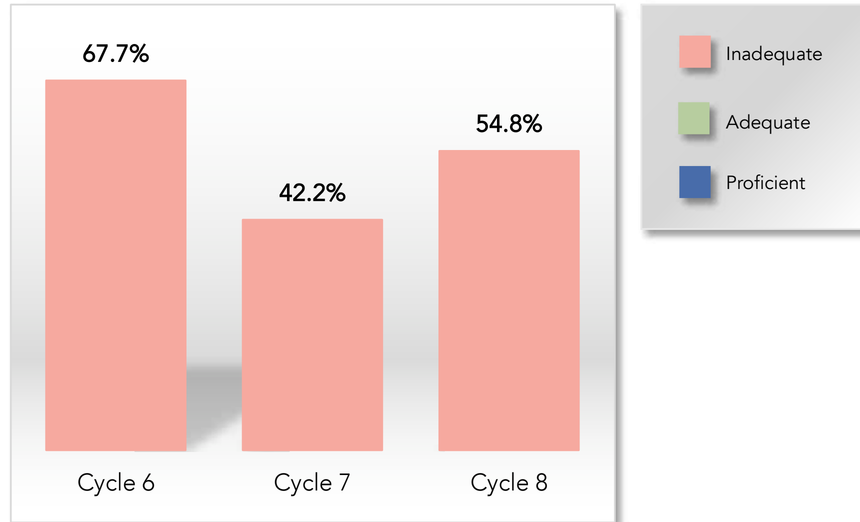
following deficiencies: the PIC did not initiate the medication follow-up report timely; the reports contained no evidence either the prescriber or the patient were notified of the medication errors; and several medication error follow-up forms were completed incorrectly, specifically, the initiation date of the form preceded the actual date of the incident (MIT 7.112, 4.0%).

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 SATF, 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. Two of the 10 applicable patients interviewed indicated they had access to their rescue medications. Eight patients did not have their rescue medications on person and expressed need for replacement. We promptly notified the CEO of this concern, and health care management immediately issued replacement rescue inhalers to the patients (MIT 7.999, N/A).
- We also note the compliance test in MIT 7.006 was deemed not applicable during the reporting period as no qualifying patients laid over at SATF requiring evaluation of medication continuity (MIT 7.006, N/A).

Analysis of Performance Across Inspection Cycles

Figure 7. Medication Management, Compliance Scores Across Cycles



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

In Cycle 8, SATF performed below established standards for medication management, highlighting a significant need for improvement. The institution did not meet the 75.0-percent compliance threshold for medication management, attaining only 54.8 percent in Cycle 8. While this score demonstrates improvement from 42.2 percent in Cycle 7, it is lower than the 67.7 percent achieved in Cycle 6, indicating the overall performance in this indicator remains consistently below adequate levels.

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)	3	14	8	17.6%
Did health care staff make available, new order prescription medications to the patient within the required time frames? (7.002.1)	16	2	7	88.9%
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)	14	6	5	70.0%
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)	8	10	7	44.4%
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)	10	10	5	50.0%
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)	14	11	0	56.0%
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)	N/A	N/A	N/A	N/A
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)	9	0	1	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	6	3	1	66.7%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	7	2	1	77.8%
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)	8	1	1	88.9%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	3	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	0	4	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	4	2	4	66.7%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications? (7.109)	0	1	0	0

Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	1	24	0	4.0%
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): **54.8%**			

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 in all settings 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

Compliance Rating
ADEQUATE

Compliance Score
(81.8%)

SATF achieved sufficient compliance performance in this indicator. Based on the overall compliance score result of 81.8 percent, the OIG rated this indicator

Compliance Testing Results

SATF 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 all 25 patients (MIT 9.004, 100%).
- 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.

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

- The institution transferred out patients identified at the highest risk of contracting coccidioidomycosis (valley fever) infection for nine of 11 patients (MIT 9.009, 81.8%). For two patients, they were transferred nine and 62 days late from the required time frame.

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

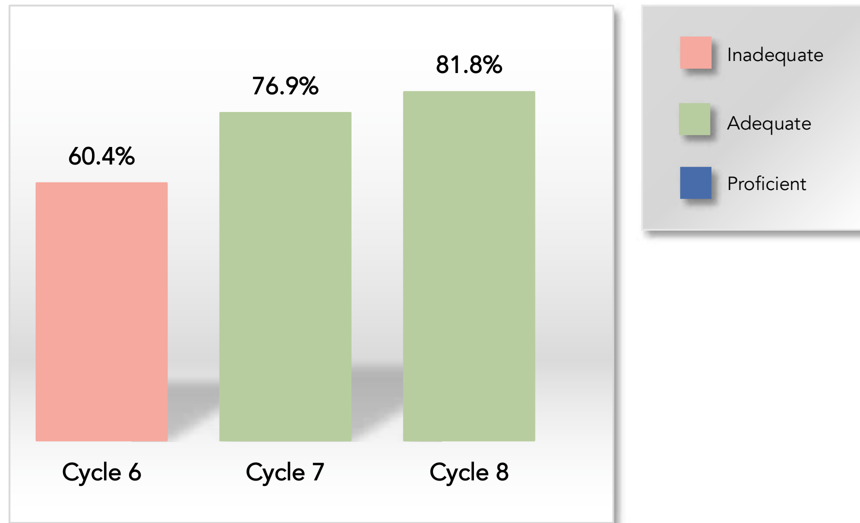
- The institution demonstrated opportunities for improvement in administering TB medications for 18 of 25 sampled patients (MIT 9.001, 72.0%). For seven patients, we found one or more of the following deficiencies: incomplete documentation of the patient's reason for refusing medication, incomplete documentation of the patient's reason for not presenting to the medication line, or the record contained no evidence whether patients refused or received medications.

- The institution monitored patients taking TB medications during the treatment period for 18 of 25 sampled patients (MIT 9.002, 72.0%). In seven patients, we found one or more of the following deficiencies: medical staff failed to document and address the required clinical symptoms and potential adverse drug reactions in the TB Screening Evaluation Report or the record contained no evidence a monthly monitoring was completed within policy requirements.

- The institution offered immunizations to chronic care patients for six of 11 sampled patients (MIT 9.008, 54.5%). For five patients, the record contained no evidence showing whether chronic care patients received or refused their pneumococcal vaccinations.

Analysis of Performance Across Inspection Cycles

Figure 8. Preventative Services, Compliance Scores Across Cycles



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

In Cycle 8, SATF 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 81.8 percent in Cycle 8. This rating demonstrates consistently improved performance in this indicator from 60.4 percent in Cycle 6 and 76.9 percent in Cycle 7, indicating the institution is trending toward proficient performance in this indicator.

Table 19. Preventive Services Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	**No**	**N/A**	**Yes %**
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	18	7	0	72.0%
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)	18	7	0	72.0%
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)	25	0	0	100%
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)	6	5	14	54.5%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	9	2	0	81.8%
Overall percentage (MIT 9): **81.8%**				

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.

Nursing Performance: Case Review Ratings and Results Summary

SATF nurses performed well with patients returning from an off-site specialty services or procedures. SATF nurses generally delivered appropriate and timely nursing care throughout the institution, including outpatient settings, triage and treatment area (TTA), specialized medical housing (SMH), transfers in process, hospital returns, and specialty services returns. However, among areas of generally satisfactory performance, our clinicians identified patterns in which nurses did not perform complete assessments. We also found nurses required significant improvement to reduce patient risk in the transfer-out process and in medication management. Considering all factors, the OIG rated this indicator ***adequate.***

Table 20. Nursing Performance Case Review Results

Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
168	86	25

* We reviewed 168 nursing encounters in 48 cases. Of the nursing encounters we reviewed, 77 occurred in the outpatient setting.

† Deficiencies occurred in cases 1, 2, 6–12, 18–23, 29–32, 34, 35, 39–43, 46, 48, and 52–55.

‡ Significant deficiencies occurred in cases 1, 2, 8–10, 12, 22, 23, 30, 32, 35, and 40.

Table 21. Case Review Outpatient Nursing Performance Results

Outpatient Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
77	50	12

* Nursing outpatient encounters occurred in cases 1, 2, 8–11, 18–23, and 33–56. Among all the outpatient nursing events, 46 were sick call events. Sick call events occurred in cases 1, 2, 8, 9, 11,18–21, 23, and 33–56.

† Outpatient nursing deficiencies occurred in cases 1, 2, 8–12, 18–20, 22, 23, 34, 35, 39–43, 46, 48, and 52–55.

‡ Outpatient nursing significant deficiencies occurred in cases 1, 2, 8, 10, 12, 22, 35, and 40.

Performed well

OIG clinicians found SATF nurses performed well in the following:

- Specialty Services

  Nurses almost always completed good assessments and communicated information to the providers after patients returned from specialty appointments. Please refer to the **Specialty Services** indicator for further details.

Performed Satisfactorily with Opportunities for Improvement

Our clinicians found SATF nurses performed satisfactorily with opportunities for improvement in the following:

- Outpatient Nursing Assessment, Interventions, and Documentation

  Nurses generally provided appropriate nursing assessments, interventions, and triaged sick call requests timely. The following examples showed room for improvement:

  - In case 1, the nurse assessed the patient for complaints of swelling and pain to the right foot and lower leg. The nurse indicated the patient had swelling to the right foot and lower leg with redness, no open wounds, and severe pain. However, the nurse did not complete a thorough assessment including documenting when the symptoms began, the duration of the symptoms, the symptom's progression, or any alleviating factors. In addition, the nurse did not assess pulses to the foot, did not listen to lung sounds, did not complete a cardiac system assessment, and did not document measurements of the swelling. The nurse also documented the plan to give Tylenol. However, we found no active order for Tylenol and no evidence the patient received the

medication. Additionally, the nurse did not consult with the provider regarding the abnormal findings for further plan of care.

- In case 10, the nurse assessed the patient with a history of inflammation of the colon and cardiac disease for complaints of upper abdominal pain radiating to the chest area. The patient reported feeling nauseated for a few days and stated the pain had started one hour prior while resting in the cell. The nurse documented using the RN standard protocol and administered anti-nausea medication. The nurse scheduled the patient for a provider follow-up appointment, and the patient returned to the housing unit. However, the nurse did not perform a complete assessment, including an EKG, for the patient's complaint of chest pain.[53] In addition, the nurse did not consult with the provider regarding the abnormal findings for further evaluation and discharged the patient without providing education.

- In case 40, the nurse assessed the patient for a complaint of a rash on his legs. The nurse incorrectly triaged the patient's complaint regarding the rash on his legs as asymptomatic instead of symptomatic. In addition, the nurse did not assess the legs, take vital signs, or assess the patient for discomfort or pain.

SATF nurses performed satisfactorily with completing accurate documentation. However, OIG clinicians identified 16 documentation deficiencies, one of which was significant.[54] The following are examples:

- In case 8, the nurse assessed the patient for complaints of chronic severe back pain, not eating, and urinary incontinence. The nurse contacted the provider, and the patient was transferred to the TTA for further evaluation. The clinic nurse documented the patient was experiencing stroke-like symptoms but also documented patient was negative for neurological deficits and speech was clear. The nurse also documented the patient was negative for genitourinary symptoms but reported urinary incontinence.[55]

- In case 18, the patient complained of having a rash. The nurse evaluated the patient but did not document the location and size of the rash.

[53] 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.

[54] Documentation deficiencies occurred in cases 8, 9, 10, 11, 18, 22, 23, 34, 43, 46, 48, and 53. A significant deficiency occurred in case 22.

[55] The genitourinary system consists of the organs responsible for urinary excretion and reproduction, including the kidneys, bladder, ureters, urethra, and reproductive structure. Urinary incontinence is the involuntary or accidental leakage of urine due to loss of bladder control.

- Care Coordinators and Care Managers

  OIG clinicians reviewed five cases in which a care coordinator or care manager provided care to patients. We identified three deficiencies, none of which were significant.[56] The following is an example:

  - In case 2, the care manager nurse assessed the newly arrived patient with multiple chronic care conditions, including asthma, COPD, and chest pain. During the care manager appointment, the nurse did not review the patient's chart for medication compliance or inquire whether the patient had his prescribed emergency medications, Xopenex and nitroglycerin.[57]

- Emergency Services

  OIG clinicians found SATF nurses performed adequately in emergency services. However, we identified opportunities for improvement with nursing assessments, interventions, and documentation. Please refer to the **Emergency Services** indicator for further details.

- Hospital Returns

  SATF nurses generally performed appropriate assessments when patients returned from a hospitalization. However, we identified opportunities for improvement in medication continuity for patients who returned from a hospitalization or emergency room encounters. Please refer to the **Transfers** indicator for further details.

- Specialized Medical Housing

  SATF's CTC nurses generally performed good assessments, completed thorough admission assessments, conducted rounds as required, and maintained medication continuity for patients newly admitted to the CTC. Please refer to the **Specialized Medical Housing** indicator for further details.

- Transfers In

  SATF nurses performed sufficiently overall in the transfer-in process. The nurses screened patients appropriately for patients who transferred into the facility. Nurse and provider appointments occurred timely. However, we identified opportunities for improvement in medication continuity for patients transferring into the facility. Please refer to the **Transfers** indicator for further details.

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[56] Care coordination and care manager events occurred in cases 1, 2, 8, 9, and 23. Deficiencies occurred in cases 2 and 9.

[57] Chronic obstructive lung disease (COPD) is a chronic and progressive lung disease that damages lung tissue and restricts airflow. Xopenex is an inhaler medication which treats asthma by relaxing the muscles in the airways, allowing them to open and making it easier to breathe. Nitroglycerin prevents and treats chest pain by relaxing the blood vessels.

- Wound Care

  We reviewed one case in which SATF nurses provided wound care and identified three deficiencies, one of which was significant.[58] Nurses intermittently performed incomplete wound assessments, performed incomplete documentation, and did not consult with the provider when a change in condition was noted. The following is an example:

  - In case 22, nurses frequently performed wound care for this patient in November 2025. During the review period, nurses often performed dressing changes, but they did not always document the wound (drainage) characteristics and did not always perform wound care as ordered. On one occasion, the nurse assessed this patient's wound and documented the wound had increased in size and had a heavy amount of drainage with a mild odor, indicating possible infection. However, the nurse did not consult a provider regarding this significant change.

Performed Poorly, Improvement Needed

OIG clinicians found SATF nurses performed poorly in the following:

- Transfers Out

  We found SATF nurses did not consistently ensure they met all transfer requirements for patient transfers out of the institution, and nurses did not always communicate pending specialty appointments to the receiving institution. Additionally, we found patients did not always transfer with their prescribed medications. Please refer to the **Transfers** indicator for further details.

- Medication Management

  OIG clinicians found SATF overall needed improvement in medication management. We identified lapses in medication continuity throughout the institution, which led to multiple cases in which patients did not receive chronic care medications for a month or more. We also identified a similar trend of lapses in medication continuity for patients returning from hospitalizations. In addition, we identified nursing medication documentation discrepancies, which contributed to the patients not receiving medications timely. Please refer to the **Medication Management** indicator for further details.

[58] Wound care events occurred in case 22. All three deficiencies occurred within this case.

Clinician On-Site Inspection

During our on-site inspection, OIG clinicians inspected the TTA, CTC, R&R, outpatient clinics, and medication administration areas, and we interviewed the nurses in each area. We attended two well-organized care team huddles on C and E Yards. Both the C and E care teams were extremely knowledgeable regarding their patient populations. Our clinicians were impressed with the C yard sick call request triage process and the E yard process for addressing potential continuity of care issues with patients who were hospitalized but expected to return during the weekend. The clinic RNs for the C Yard reported seeing an average of 15 to 20 patients per day and discussed large increases in sick call requests submissions during modified or lockdown programs.[59] To mitigate this issue, nurses reported sending patients letters to inform them their complaints were being addressed and giving a time frame or update, if appropriate. At the time of our inspection, both the C and E care teams reported no backlog during huddle, despite frequent schedule disruption from modified or lockdown programs. Both C and E yard care teams actively participated during the huddle and completed an action item log for any huddle follow-up questions.

Our clinicians interviewed the clinic medication management LVNs in several of the outpatient clinics including B, C, and D yards. C yard LVNs reported many challenges with medication management including frequent modified or lockdown programs as well as a diverse patient population with greater challenges all housed within the same yard and often in the same buildings. In addition, C yard consisted of eight buildings and, thus, housed the largest yard population with the highest number of patients requiring medications.

During our on-site inspection, we met with the chief nurse executive (CNE). Nursing leadership discussed medication administration challenges, particularly on C yard, and discussed changes SATF implemented to decrease medication management lapses. Nursing leadership discussed challenges with filling various LVN vacancies and with using registry nursing staff and newly hired LVNs to fill shifts. The CNE specifically expressed concerns with using registry staff due to the limited training they receive (which is the standard training by CCHCS) and using newly trained LVNs in the more challenging areas due to their inexperience with working in these settings.

Nursing staff reported they felt supported in their roles, and nursing morale was positive. In addition, the CNE expressed pride in SATF's active recognition process for nursing staff.

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[59] A "modified program" or "lockdown program" is a temporary change to regular prison operations. CDCR uses this status to protect safety and security when the institution experiences an elevated threat or ongoing investigations such as after violence, contraband discoveries, or other serious incidents

Case Review Recommendations

- Nursing leadership should determine the root cause(s) of challenges preventing nurses from performing complete assessments and 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.

Provider Performance: Case Review Ratings and Results Summary

Case review found SATF provider performance worsened since Cycle 7. SATF providers performed well in provider continuity as well as outpatient documentation quality and performed satisfactorily with opportunities for improvement in emergency care and outpatient review of records. However, providers delivered poor care in assessment and decision making in both the outpatient and specialized medical housing settings. In addition, providers often did not follow specialists' recommendations and poorly managed chronic care conditions such as diabetes and anticoagulation. After careful consideration of all aspects of provider performance, the OIG rated this indicator ***inadequate***.

Table 22. Provider Performance Case Review Results

Provider Encounters*	Deficiencies†	Significant Deficiencies‡
136	102	57

* The OIG reviewed 136 provider encounters.

† Deficiencies occurred in cases 1, 2, 8–10, 12–25, and 32.

‡ Significant deficiencies occurred in cases 1, 8, 9, 10, 12–18, 20–22, 24, 25, and 32.

Table 23. Provider Performance Detailed Cases Results

Total Detailed Cases reviewed	Proficient	Adequate	Inadequate
20	0	10	10

Performed Well

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

- Provider Continuity
- Outpatient Documentation Quality

Performed Satisfactorily with opportunities for improvement

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

- Emergency Care

  SATF providers performed acceptably with emergent or urgent care. Providers generally evaluated patients and made treatment decisions appropriately. OIG clinicians identified three deficiencies, one significant and two minor.[60] We discuss further in the **Emergency Services** indicator. The following deficiency is an example:

  - In case 8, the provider evaluated the patient in the TTA for back pain. However, the provider did not perform a thorough subjective and objective assessment of the patient's back pain.

- Outpatient Review of Records

  In the 93 outpatient provider encounters, providers often reviewed records appropriately; however, OIG clinicians identified eight deficiencies, three of which were significant.[61] The following are the significant deficiencies:[62]

  - In case 12, the provider ordered a laboratory test for the patient. However, the test was not completed due to a sample collection error. The provider did not thoroughly review this and sent a patient notification letter stating the test result was "as expected."

  - In case 21, the CTC provider performed an admission history and physical examination for a patient but did not review the hospital discharge recommendations thoroughly. The provider missed the recommendation to begin a cholesterol medication, atorvastatin, at 80 mg for secondary stroke prevention for the patient.

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[60] Deficiencies occurred in cases 8 and 15. A significant deficiency occurred in case 8 and is discussed in the **Emergency Services** indicator.

[61] Deficiencies occurred in cases 1, 12-13, 21, 25 and 32. Significant deficiencies occurred in cases 12 and 21.

[62] We discuss the third significant deficiency in the **Specialized Medical Housing** indicator.

- Also in case 21, the CTC provider evaluated the patient after the patient refused a fine needle aspiration procedure of a thyroid nodule.[63] A possible cause of the thyroid nodule is cancer. The provider continued to document the thyroid nodule workup was in progress and did not address the patient's refusal or need for the fine needle aspiration with the patient.

Performed Poorly, Improvement Needed

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

- Chronic Care

  Appropriate and timely management of patients' chronic medical conditions improves long term patient health and reduces emergency events. OIG clinicians reviewed 23 provider events involving chronic care and identified 33 deficiencies related to care of chronic conditions. Of those deficiencies, 18 were clinically significant.[64] The following are examples of the significant deficiencies:

  - In case 13, the provider evaluated the patient at a chronic care appointment to address the patient's worsening diabetes. The provider started the patient on long-acting insulin and documented the provider would review the blood sugar readings in two weeks. The patient's blood sugars remained very elevated for the next two weeks, indicating the diabetes was still uncontrolled. This resulted in an emergent condition of high blood sugar with the patient requiring care in the TTA. The provider should have reassessed the patient sooner and adjusted the patient's diabetes medications.

  - In case 14, the provider performed a review of the patient's medications and documented no drug-drug interactions and no duplicate medications.[65] However, the patient had been inappropriately prescribed two different statins, which increased the patient's risk for side effects and drug interactions without any additional benefit.[66]

  - In case 15, the provider evaluated the insulin dependent diabetic patient at a follow-up appointment after the patient had an emergency event for a symptomatic low blood sugar reading. The provider did not document an appropriate medical history, history of present illness, or physical examination. The provider also did not address previous endocrinology recommendations to

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[63] A fine needle aspiration is a procedure using a thin needle to obtain tissue or fluid to check for cancer.

[64] Deficiencies occurred in 1, 12-17, 19, 20, and 24. Significant deficiencies occurred in cases 1, 12-17 and 24.

[65] A drug-drug interaction is an interaction between two drugs which can increase or reduce effects of the drugs, cause side effects, or contribute to complications.

[66] A statin is a cholesterol reducing medication. Patients should not be taking more than one statin medication at the same time.

adjust the patient's diabetic regimen or order an endocrinology specialist follow-up within four weeks.[67] This increased the patient's risk for continued hypoglycemic events and uncontrolled diabetes.[68]

OIG clinicians identified 14 deficiencies related to anticoagulation medication management for chronic medical conditions; five of which were significant.[69] These deficiencies increased the risk of life-threatening bleeding, blood clots, or stroke. All the significant deficiencies occurred in case 14. The following are examples:

- The patient's INR results were elevated beyond the therapeutic level. However, the provider did not endorse and address the elevated INR result, which increased the risk of bleeding.
- Approximately six weeks later, the provider endorsed the laboratory results and created a patient notification letter stating, "Your test results are essentially within normal limits or are unchanged and no provider follow-up is required," when the INR result actually remained elevated beyond the therapeutic level and required provider action.
- Then, about three weeks later, the provider endorsed an even more elevated INR result, which further increased the risk of bleeding to the patient. The provider did not evaluate the patient for possible causes, hold the warfarin dose, or increase the frequency of INR monitoring to maintain the INR at the therapeutic target level.

- Outpatient Assessment and Decision Making

Providers frequently performed poorly in assessment or decision making. Of the 99 provider outpatient events, OIG clinicians identified 65 deficiencies, 39 of which were significant.[70] The following are examples of significant deficiencies:

- In case 9, this developmentally disabled patient arrived at SATF in early October 2025. However, the patient never received a new arrival history and physical evaluation by the provider. Instead, two days after arrival, the patient was sent to the hospital for fever and new tremors, and the patient discharged back to SATF the same day. The EHRS next showed this patient was transferred back to the hospital for a higher level of care in early November

[67] An endocrinology specialist treats and manages hormone-related medical conditions such as diabetes and thyroid disease.

[68] Hypoglycemia is a medical condition in which the blood sugar level is lower than the normal standard range, resulting in sweating, dizziness, confusion, and, rarely, death.

[69] Anticoagulation medication management refers to managing blood-thinning medications such as warfarin.

[70] Deficiencies occurred in cases 1, 2, 8–10, 12–20, 23–25, and 32. Significant deficiencies occurred in cases 1, 8–10, 12–18, 20, 24, 25, and 32.

2025, and he passed away in the hospital 11 days later. Subsequently, in December 2025, the provider entered a progress note indicating the provider had seen the patient for a follow-up after the hospitalization in October 2025. The progress note indicated the provider evaluated the patient for new onset ataxia (difficulty walking). However, the provider did not review the chart to assess the duration and progression of the patient's new onset ataxia. Instead, the provider took the developmentally disabled patient's verbal history that this was a chronic condition the patient had since a previous "stroke," and the provider did not perform any further workup. The patient was a known poor historian and had no stroke history. The provider simply ordered the patient a wheelchair without further assessment. No further provider appointments occurred between this appointment and the patient's subsequent final transfer to the hospital in November 2025.

- Also in case 9, we identified the following additional errors:
    - The provider did not review the patient's medical chart to recognize the patient had lost over 28 pounds since his recent arrival to CDCR.
    - The provider did not take a good medical history or perform an appropriate physical examination.
    - The provider did not address the patient's elevated heart rate or low oxygen saturation.
    - The provider did not address the hospital diagnosis of anemia.
    - The provider did not acknowledge the hospital chest x-ray which showed abnormal thoracic compression fractures, which would be highly unusual in a 37-year-old male.[71] These "compression fractures" were subsequently diagnosed as disseminated coccidiomycosis lesions.[72]

- In case 10, an RN co-consulted a provider about this patient's complaints of abdominal pain radiating to chest with changing oxygen saturation levels. The patient has a history of heart failure, ischemic cardiomyopathy, coronary artery disease, chronic kidney disease, and recent hospitalization with steroid medication.[73] The RN documented the provider ordered gastrointestinal medications for seven days to treat abdominal cramping as well as a follow-up appointment with a provider four days later. The provider should have considered other differential diagnosis for the upper epigastric pain radiating

[71] A thoracic compression fracture occurs when a spine bone in the mid back collapses. Causes include trauma, osteoporosis, cancer, and infections.

[72] Coccidioidomycosis is also known as Valley Fever. It is a fungal infection that enters the body through inhalation of spores found in the soil in certain parts of the southwestern United States. This infection can affect the lungs, skin, joints, hone, and brain.

[73] Ischemic cardiomyopathy is a condition with weakened heart pumping function due to reduced blood flow in blood vessels supplying blood to the heart.

to the chest, including cardiac causes, and considered sending the patient for higher level of care.

- In case 17, the provider evaluated the patient with a history of constipation and glaucoma for urinating four to six times every night. The provider diagnosed the patient with overactive bladder and prescribed oxybutynin.[74] However, the provider did not perform a physical examination, order a urine test to check for blood or infection, or consider other causes. In addition, use of oxybutynin may worsen the patient's conditions of constipation and glaucoma.[75]

- Patient Notification Letters

  Providers needed improvement in relaying complete diagnostic test result notification letters to their patients. Providers often sent incomplete patient test result notification letters or did not send them at all.[76] We discuss further in the **Diagnostic Services** indicator. The following are examples:

  - In case 14, the provider reviewed the results of a blood-thinning level test that was beyond the therapeutic range. However, the provider erroneously sent the patient letter stating the results were "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.

- Specialized Medical Housing

  SATF providers performed poorly in care of specialized medical housing patients. OIG case reviewers identified 20 deficiencies, 12 of which were significant. We discuss further in the **Specialized Medical Housing** indicator.

- Specialty Services

  SATF providers generally referred patients appropriately to specialty services for medically appropriate time frames. After the specialty service appointment occurs, the providers are responsible for endorsing specialty consultation notes timely and either ensuring the specialist's recommendations are followed or documenting medical reasoning as to why they are not. We evaluated 80 specialty service appointments, wherein we identified 20 specialty services deficiencies including not following specialist recommendations, not ordering referrals for appropriate time frames, and not endorsing

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[74] Oxybutynin is a medication used to treat overactive bladder by affecting the nerve receptors to relax the bladder muscles.

[75] Worsening glaucoma can lead to blindness, and worsening constipation can lead to bowel obstruction and pain.

[76] Deficiencies occurred in cases 8–11, 14–19, 22, 23, 32, and 33. A significant deficiency occurred in case 14.

specialist's consultation notes timely.[77] Fifteen of these deficiencies were medically significant. The following are examples:

- In case 14, the cardiologist evaluated the patient for further management of aortic valve replacement and history of coronary artery bypass graft surgery.[78] The cardiologist recommended to schedule a follow-up appointment in six weeks' time and to obtain several important heart studies. The provider did not endorse the specialist's report for almost one month. The provider also did not order a follow-up appointment with cardiology within the requested time frame. Furthermore, the provider did not order the requested heart studies (nuclear myocardial perfusion scan, echocardiogram, and Holter monitor) within the recommended time frame.[79] This delayed specialty care to the patient.

- In case 24, the urologist evaluated the patient for possible prostate cancer. The urologist requested a prostate biopsy; however, the provider ordered the biopsy to occur within 90 days when it should have been ordered with more urgency. Three months later, when the biopsy was completed, the results showed prostate cancer. The provider did not schedule an appointment with the patient to discuss this important finding.

- In case 25, the orthopedic surgeon performed right knee arthroscopy for ACL and meniscal repairs.[80] On four separate sequential orthopedic specialty appointments, spanning nearly three months, the orthopedic surgeon recommended the patient undergo physical therapy to improve healing, strength, and range of motion. However, no provider ordered the postoperative physical therapy as the orthopedic surgeon requested.

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[77] Deficiencies were identified in cases 10–14, 21, 22, 24, and 25. Significant deficiencies were identified in cases 11–14, 21, 22, 24, and 25.

[78] The aortic valve controls the flow of blood from the left side of the heart to the aorta, the body's largest artery that delivers oxygenated blood to the body. Coronary bypass graft surgery treats a blocked or narrowed heart blood vessel by creating a new path to restore blood flow.

[79] A nuclear myocardial perfusion scan is an imaging study using radioactive tracer to show how well blood flows through the heart. An echocardiogram is a procedure using an ultrasound to image the heart and evaluate its pumping function. A Holter monitor is a wearable device that records a patient's cardiac electrical activity for set number of hours or days.

[80] An arthroscopy is a joint procedure using a camera with light to diagnose and treat. ACL is the anterior cruciate ligament of the knee and provides structure and stability in the knee joint.

Clinician On-Site Inspection

OIG clinicians met with the longstanding chief medical executive (CME), chief physician and surgeon (CP&S) of three years, and various providers. The prior CP&S left SATF for a promotion in another institution, and a telemedicine CP&S is temporarily serving at SATF at the time of our inspection. Both the CME and CP&S were well regarded by the providers. The providers expressed support by their leadership and felt the leadership was approachable and helpful. Most providers had been at SATF for a long time.

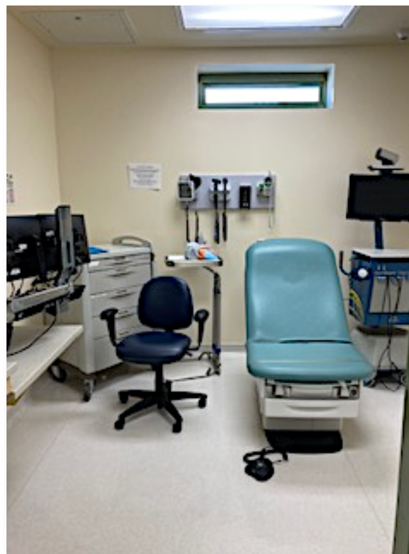

Photo 26. Examination room in E clinic. Photographed 3-18-2026.

Medical leadership identified some staff experiencing personal issues may have led to some of the documentation deficiencies OIG clinicians identified. Providers generally reported feeling supported by leadership, and when leadership identified documentation deficiencies, the appreciated the additional guidance and instruction. One provider also reported leadership coordinated their move to a different yard, which the provider felt was beneficial.

Medical leadership reported SATF is allotted 17 primary care provider positions for 10 clinics, the TTA, and the CTC. Leadership stated SATF had 5.5 provider vacancies during our review period, with 2.5 positions filled by registry staff and one provider on long term leave. The two CP&Ss oversaw SATF's nine advanced practice providers (NPs and PAs).[81] Telemedicine providers helped with patient care when on-site providers were not available. Most clinics had two assigned providers. On most clinic yards, the mid-level practitioners were paired with either an on-site or telemedicine physician. The physicians routinely evaluated more medically complex patients. Most providers worked four 10-hour shifts per week, seeing between 10 and 14 patients per day with nursing consultations. The providers' clinic partners covered their EHRS work inbox when on leave. Leadership required all inbox patient medical issues to be addressed at the end of each business day to reduce the covering provider's workload. The providers we spoke to reported the ten-hour, four-day workweek schedule was beneficial.

The on-site physicians mostly covered evening and weekend on call, although this was available to the advanced practice providers as well. For the last year, a telemedicine "nocturnist" covers on call from 8pm to 6am, Monday through Thursday. Leadership stated this arrangement is working well and the provider staff expressed appreciation for this service.

[81] Advanced practice providers are nurse practitioners (NPs) and physician assistants (PAs).

Case Review Recommendations

- Medical leadership should develop, implement, and monitor strategies, such as more frequent training or oversight, to improve performance for those providers who have the most provider performance deficiencies in our case reviews.

- Medical leadership should develop, implement, and monitor strategies such as provider training, to improve provider performance on managing chronic medical conditions, including diabetes management and anticoagulation with warfarin.

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

Specialized Medical Housing: Case Review Ratings and Results Summary

SATF's medical care was mixed for specialized medical housing patients. CTC nurses generally performed good assessments, completed thorough admission assessments, conducted rounds as required, and maintained medication continuity for patients newly admitted to the CTC. However, the OIG clinicians identified poor provider performance with patterns of questionable decision making and inaccurate or incomplete documentation. Considering all factors, the OIG rated the case review component of this indicator ***inadequate.***

Table 24. Specialized Medical Housing Case Review Results

CTC Events*	Deficiencies†	Significant Deficiencies‡
75	33	13

* We reviewed four CTC cases that included 22 provider encounters and 31 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 2, 21, 22, and 32.

‡ Significant deficiencies occurred in cases 21, 22, and 32.

Performed Well

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

Performed Satisfactorily with Opportunities for Improvement

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

- Nursing Performance[82]

  OIG clinicians found CTC nurses completed thorough admission assessments and initiated appropriate care plans. The CTC nurses assessed their patients each shift, provided patient education, conducted rounds as required, and generally provided satisfactory patient care. However, we identified a pattern of deficiencies related to incomplete nursing assessments and documentation.[83] The following are examples:

  - In case 21, from September to December 2025, the CTC nurses frequently documented “localized abnormality” for the skin assessments. However, the CTC nurses did not describe the skin abnormality.

  - In case 22, the CTC LVN administered Tylenol for oral pain. The LVN noted the patient’s pain had improved. However, the LVN did not obtain subjective information on the pain severity, onset, or duration. In addition, the LVN did not notify the registered nurse (RN) of this new complaint.

  - In case 32, from August to November 2025, the provider ordered a chronic medication to treat high blood pressure and ordered parameters to hold the medication if the blood pressure and heart rate fell below a certain range. However, nurses frequently did not check the patient’s blood pressure and heart rate prior to administering the evening dose of the medication.

- Medication Management[84]

  Newly admitted patients to the CTC received their medications without lapses in medication continuity. OIG clinicians found most patients in the CTC received their medications timely. Please refer to the **Medication Management** indicator for further information.

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[82] Nursing performance deficiencies occurred in cases 2, 21, 22, and 32. A significant deficiency occurred in case 32.

[83] A pattern of incomplete nursing assessments and documentation deficiencies occurred in cases 2, 21, 22, and 32.

[84] Medication management deficiencies occurred in cases 21, 22, and 32. No significant deficiencies.

Performed Poorly, Improvement Needed

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

- Provider Performance

  Providers usually evaluated the patients in CTC timely. However, OIG clinicians identified 20 deficiencies, 12 of which were significant.[85] We identified patterns of questionable decision making and inaccurate or incomplete documentation. The following are examples:

  - In case 21, the provider discharged a patient who needed help with activities of daily living from the CTC back to the general housing outpatient setting. However, documentation in the EHRS indicated other providers were still in the process of conducting a cognitive evaluation as the patient was not able to perform self-care. Discharging the patient back to the general housing outpatient setting increased the significant risk of harm to the patient.

  - In case 22, the provider documented "Complicated UTI" and "Initiate bactrim" in the assessment and plan for the patient who already developed a rash following a previous administration of the same antibiotic.[86] The provider used the "copy and paste" functionality without editing and did not ensure up-to-date and accurate documentation. Subsequently, the provider used the outdated information for the plan of care for the patient's rash and ordered the same Bactrim antibiotic. Furthermore, the provider did not document conducting a skin examination of the continuing rash. The next day, the patient required a steroid medication to treat the rash from another provider.

  - In case 32, the provider repeatedly documented the same errors throughout the review period, such as documenting medications the patient was not taking and physical exams and findings from previous encounters.

Clinician On-Site Inspection

Our clinicians toured the CTC and interviewed nursing staff. At the time of the on-site inspection, the CTC had 18 medical beds, 20 mental health crisis beds, and 10 negative pressure rooms. All beds were occupied. The nursing supervisor stated the CTC was staffed with a mixed ratio of RNs, PTs, LVNs, and a shift lead nurse for the day and evening shifts. Staff held huddles daily and included all required members. The CTC had a designated provider during business hours. After hours, the nurses contacted the on-call provider for any problems or orders. Staff

[85] Deficiencies occurred in cases 21-22, and 32. Significant deficiencies occurred in all three cases.

[86] UTI is an acronym for urinary tract infection. Bactrim is an antibiotic commonly prescribed for urinary tract infections.

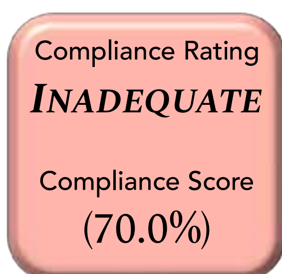
reported feeling supported by executive staff and having a good working relationship with custody.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure nurses perform thorough patient assessments and document their findings. Nursing leadership should implement and monitor remedial measures as appropriate.

- Medical leadership should identify the root cause of poor provider decision-making and inaccurate documentation of patient care for CTC patients and should implement and monitor remedial measures as appropriate.

Specialized Medical Housing: Compliance Ratings and Results Summary



SATF presents opportunities for improvement in this indicator. Based on the overall compliance score result of 70.0 percent, the OIG rated the compliance component of this indicator ***inadequate.***

Compliance Testing Results

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

- Providers performed excellently in completing written history and physical examinations within the required time frame for all six sampled patients (MIT 13.002, 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%).
- The institution maintained an operational call light system (MIT 13.101, 100%).

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

- The RNs demonstrated good performance in completing an initial assessment of the patient at the time of admission for five of six sampled patients (MIT 13.001, 83.3%). For one patient, the RN did not complete the initial assessment timely.

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

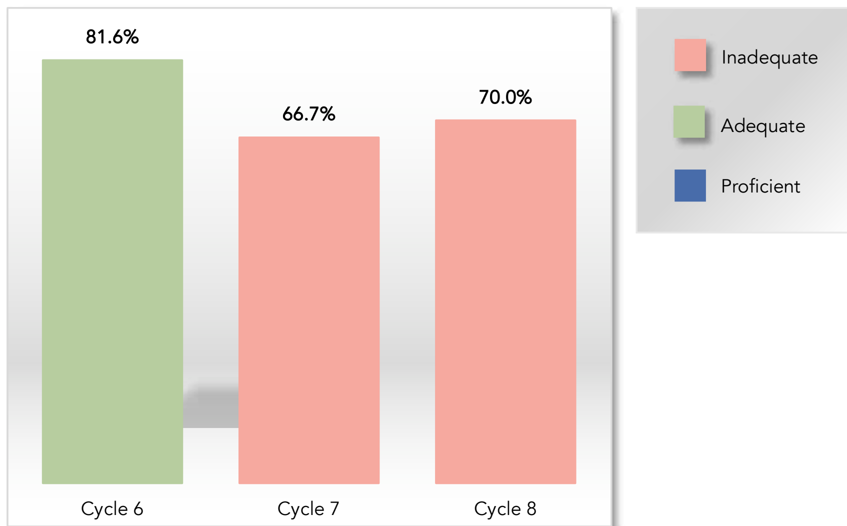
- Health care staff ensured all ordered medications were made available for only one of five applicable sampled patients within the required time frame (MIT 13.003.2, 20.0%). For four patients, the pharmacy was not timely in filling and dispensing medications as ordered.
- Health care staff ensured all ordered medications were administered to the patient for only one of six sampled patients within the required time frame (MIT 13.003.3, 16.7%). For five patients, we found one or both of the following deficiencies: nursing staff did not administer direct observation therapy (DOT) or nurse administered (NA) medications within the provider's ordered timelines, or the record contained no evidence indicating whether the patient refused or received medication.

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

- SATF has a local operating procedure in place for performing safety checks and rounds when the call light system is in disrepair. At the time of inspection, the call light system was operational; therefore, this test was not applicable (MIT 13.102, N/A).

Analysis of Performance Across Inspection Cycles

Figure 9. Specialized Medical Housing, Compliance Scores Across Cycles



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

In Cycle 8, SATF continued to perform below established standards. The institution did not meet the 75.0-percent compliance threshold for this indicator, reaching only 70.0 percent in Cycle 8. Although this demonstrates a slight improvement from 66.7 percent in Cycle 7, the score remains lower than the 81.6 percent achieved in Cycle 6, highlighting continued need for improvement in this indicator.

Table 25. 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)	5	1	0	83.3%
Was a written history and physical examination completed within the required time frame? (13.002)	6	0	0	100%
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	4	1	20.0%
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)	1	0	0	100%
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)	0	0	1	N/A
Overall percentage (MIT 13): **70.0%**				

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

Compliance Recommendations

- Nursing leadership should determine the root cause of challenges preventing patients from receiving all ordered medications within the time frame required. Leadership 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 SATF performed acceptably in delivering specialty services for its patients. Nurses almost always completed good assessments and communicated information to the providers after patients returned from specialty appointments. SATF performed satisfactorily in specialty service access and health information management, but OIG clinicians identified some opportunities for improvement. Providers also appropriately referred patients to specialists when medically indicated; however, they did not consistently follow through with specialists' recommendations. After considering all aspects of specialty care, the OIG rated the case review component of this indicator ***adequate***.

Table 26. Specialty Services Case Review Results

Specialty Services Related Events*	Deficiencies†	Significant Deficiencies‡
114	19	6

* The OIG reviewed 114 events, including 73 specialty consultations and procedures, 16 provider encounters, four nursing encounters, and 21 specialty encounters that were scheduled and the patient refused.

† Deficiencies occurred in cases 10–14, 19, 20, 24, and 25.

‡ Significant deficiencies occurred in cases 11, 14, 20, 24, and 25.

Performed Well

OIG clinicians found SATF performed well in the following area:

- Nursing Performance[87]

[87] One minor deficiency occurred in case 19.

Performed Satisfactorily, with Opportunities for Improvement:

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

- Access to Specialty Services

  OIG clinicians identified three deficiencies with patient access to specialty services, two of which were significant.[88] The following are the two significant deficiencies:

  - In case 20, the provider ordered a shoulder MRI, but this study occurred three weeks late. Later in case 20, the provider ordered a cardiology specialty follow-up appointment. However, this appointment occurred seven weeks late.

- Health Information Management

  OIG clinicians identified eight deficiencies in 73 specialty reports, three of which were significant.[89] One minor deficiency related to ancillary staff not forwarding the specialty report to the provider, while three minor deficiencies related to staff scanning specialty reports late. Four deficiencies related to late provider report endorsements, three of which were significant. The three significant deficiencies involved endorsements delayed between six and 18 days. The following are two examples:

  - In case 11, the provider endorsed the endocrinology specialty report 17 days late.

  - In case 24, the provider endorsed the prostate biopsy result report eight days late. The report showed the patient had prostate cancer.

Performed Poorly, Improvement Needed

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

- Provider Performance

  While SATF providers referred patients appropriately to specialists, they did not consistently follow specialists' recommendations or document their medical rationale for deviating from those recommendations.[90] Of the 16 provider deficiencies related to specialty care, four related with delays in ordering recommended antibiotics or pain medications. Four other deficiencies related to delays in ordering specialists'

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[88] Specialty service access deficiencies occurred in cases 13 and 20.

[89] HIM specialty services related deficiencies occurred in cases 11, 12, 14, and 24. Significant deficiencies in case 11 and 24.

[90] Significant provider deficiencies occurred in cases 12-14, 21-22, 24, and 25. Minor deficiencies in cases 10 and 25.

recommended follow-up tests. Two deficiencies related to providers not following specialist's recommendations. The last deficiency related to the provider not providing appropriate medical indication to order the specialty referral. The following are examples:

- In case 13, on two separate instances, the provider did not ensure the diabetic patient received immediate antibiotics after surgical procedures.
- In case 25, the general surgeon evaluated the patient for a neck mass and recommended surgical removal. The provider did not follow this recommendation to order the surgery and did not document the medical rationale.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians met with the SATF medical leadership, providers, Specialty Services SRN II, and Specialty Services schedulers. The Specialty Services SRN II was new to her position and had been the Telemedicine Specialty RN for eight years prior.

In addition to the Specialty Services SRN II, the SATF Specialty Services staff includes two off-site specialty RNs, two off-site specialty OTs, one utilization management (UM) RN who follows the hospital patients and processes all Requests for Service (RFSs), two Telemedicine Specialty RNs to support the two Telemedicine Specialty clinics, and one on-site Specialty RN.[91] Leadership reported the team processes 600 to 800 RFSs per month. The UM RN reviews the RFSs to determine whether they meet medical appropriateness criteria and forwards those RFSs requiring second-level approval to medical leadership. In addition to on-site and off-site specialty services, the team also handles all healthcare appeals. The RNs are trained in the other specialty scheduler positions and can cover for each other. Leadership reported no problems maintaining staff but noted the "Post and Bid" process can result in losing good, well-trained RNs to RNs with more seniority from other areas in the institution.

SATF primary care providers can directly order on-site optometry, hearing aid specialist, procedure clinic, physical therapy (on-site and virtual), respiratory care, and telemedicine dietician without secondary-level approval. Other on-site specialty services include orthotics, gastroenterology for colonoscopies and endoscopies, and podiatry.

The on-site scheduler reported maintaining the on-site specialist's schedules and adding appointments to the current schedule. If more patients need to be seen than the number of appointments available for a specific specialist, the specialists have agreed the scheduler can create additional appointments; however, with the high number of specialty service refusals, the specialists adjust their usual number of patients on their schedules. The scheduler mentioned

[91] The request for service (RFS) is a referral order for a specialty service appointment.

physical therapy and gastroenterology specialty appointments often do not occur timely. Physical therapy has an appointment backlog due to high demand while gastroenterology has a constant backlog due to a high refusal rate. Once patients refuse, staff are able to reschedule for future appointments.

At the time of our inspection, the off-site scheduler stated SATF had an off-site specialty services backlog of nine unscheduled appointments and 21 appointments that were scheduled but already out of compliance. ENT specialty, interventional radiology, and cardiology appointments are the most difficult to obtain timely.[92] In general, the scheduler reports appointments were difficult to schedule timely because of a high rate of patient refusals and a shortage of specialty providers in the area. CCHCS headquarters telemedicine also offers specialty appointment to SATF.

During our case reviews, OIG clinicians found a higher frequency of specialty service referral denials than at other institutions. Several providers mentioned difficulty in obtaining specialty service referrals approved, even if the specialists recommend a service or procedure. In some denials, we found the providers did not revise and resubmit the referral or document reaching out to medical leadership to discuss the denial, and subsequently, patients may not have timely received the specialty services care. At our on-site inspection, medical leadership stated they implemented a system to track denied referrals to ensure patients receive the necessary care, and medical leadership will reach out to providers to discuss the referrals.

Case Review Recommendations

The OIG offers no Case Review recommendations for this indicator.

[92] An ENT specialist is an ear, nose, and throat specialist.

Specialty Services: Compliance Ratings and Results Summary

SATF exhibited strong performance in this indicator. Based on the overall compliance score result of 84.8 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

SATF 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 six and seven days late.
- The institution achieved proficiency in ensuring providers reviewed the high-priority specialty service consultant report within the required time frame for 14 of 15 sampled patients (MIT 14.002.2, 93.3%). For one patient, the provider reviewed the report one day late.
- The institution achieved proficiency in ensuring patients received medium-priority specialty services within 15 to 45 calendar days for all 15 sampled patients (MIT 14.004, 100%).
- The institution achieved proficiency in ensuring providers reviewed the medium-priority specialty service consultant report within the required time frames for 14 of 15 sampled patients (MIT 14.005.2, 93.3%). For one patient, the institution reviewed the report one day late.
- The institution ensured patients timely received their routine-priority specialty services within 90 calendar days for 14 of 15 patients (MIT 14.007, 93.3%). For one patient, the service was provided 10 days late.
- The institution achieved proficient performance in ensuring providers reviewed the routine-priority specialty service consultant report within the required time frames for 14 of 15 sampled patients (MIT 14.008.2, 93.3%). For one patient, the provider reviewed the report one day late.

- The institution achieved proficiency in providing subsequent follow-up appointments after a routine-priority specialty service for all six sampled patients (MIT 14.009, 100%).
- The institution demonstrated proficiency in timely denying the Request for Services (RFS) as required by CCHCS policy for 17 of 20 sampled patients (MIT 14.011, 85.0%). For three patients, the RFS was denied between one and three days late.
- Providers informed all 20 sampled patients of the denied RFS within the required time frame (MIT 14.012, 100%).

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

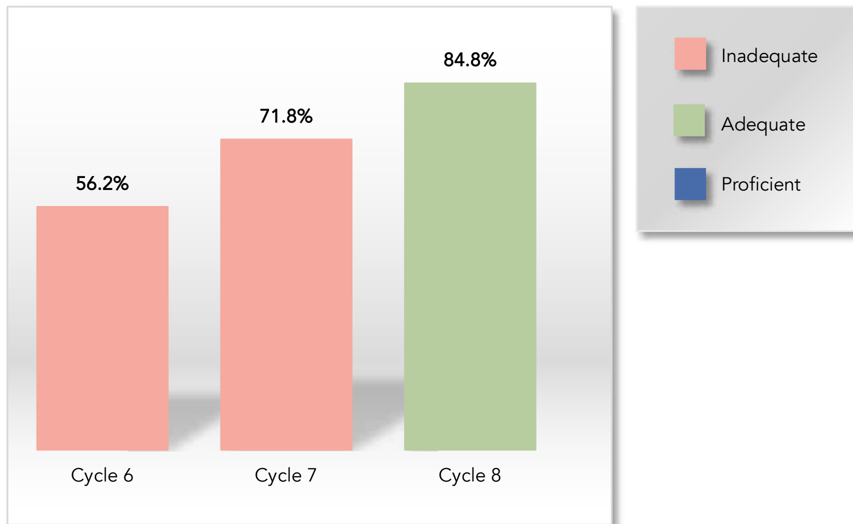
- The institution provided subsequent follow-up appointments after a medium-priority specialty service for five of six applicable sampled patients (MIT 14.006, 83.3%). For one patient, the follow-up appointment occurred 18 days late from the provider's order.
- The institution ensured patients timely received their pre-approved specialty service appointments for patients endorsed from another institution in 16 of 20 sampled patients (MIT 14.010, 80.0%). For four patients, we found the following deficiencies: the services were provided between three and 10 days late; the record contained no evidence of a signed refusal form for the refused specialty service; or the record contained no evidence the specialty service appointment occurred during our review period.

SATF 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 only 10 of 14 applicable sampled patients (MIT 14.002.1, 71.4%). For four patients, the reports were received between one and 15 days late.
- The institution provided subsequent follow-up appointments after a high-priority specialty service for five of 10 applicable sampled patients (MIT 14.003, 50.0%). For four patients, the follow-up appointment occurred between two and 20 days late from the provider's order. For the remaining patient, the record contained no evidence of a signed refusal form for the refused specialty service.
- The institution received medium-priority specialty service consultant reports within the required time frame for eight of 11 applicable sampled patients (MIT 14.005.1, 72.7%). For three patients, the reports were received between one and 12 days late.
- The institution received routine-priority specialty service consultant reports within the required time frame for nine of 13 sampled patients (MIT 14.008.1, 69.2%). For four patients, the reports were received between two and 18 days late.

Analysis of Performance Across Inspection Cycles

Figure 10. Specialty Services, Compliance Scores Across Cycles



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

In Cycle 8, SATF attained the established standards for providing Specialty Services. The institution met the 75.0-percent compliance threshold for this indicator, reaching a nearly proficient score of 84.8 percent in Cycle 8. This rating reflects steady progress from 56.2 percent in Cycle 6 and 71.8 percent in Cycle 7, demonstrating a successful commitment to improvement.

Table 27. Specialty Services Compliance Test Scores

	Scored Answer			
Compliance Questions	**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)	14	1	0	93.3%
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)	5	5	5	50.0%
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)	15	0	0	100%
Did the institution receive the medium-priority specialty service consultant report within the required time frame? (14.005.1)	8	3	4	72.7%
Did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005.2)	14	1	0	93.3%
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)	5	1	9	83.3%
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)	14	1	0	93.3%
Did the institution receive the routine-priority specialty service consultant report within the required time frame? (14.008.1)	9	4	2	69.2%
Did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008.2)	14	1	0	93.3%
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	0	9	100%
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)	16	4	0	80.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	17	3	0	85.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	20	0	0	100%
Overall percentage (MIT 14): **84.8%**				

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. Department 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. In addition, our inspectors determined whether the institution provided training and job performance reviews for its employees. We checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score. Our case review clinicians do not rate this indicator.

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

SATF demonstrated very good performance in this indicator. Based on the overall compliance score result of 89.8 percent, the OIG rated this indicator ***proficient***.

Compliance Testing Results

SATF 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%).

- The institution reviewed and completed the initial patient death reports timely for seven of eight sampled patients (MIT 15.102, 87.5%). For one patient, the report was not completed within the required time frame.

- Supervising registered nurses (RN) ensured the clinical competency of all nurses administering medications were timely completed during our review period (MIT 15.103, 100%).

- All 16 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%).

- 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 all nine patient deaths during our review period (MIT 15.998 [scored component], 100%).

SATF performed in the ***inadequate*** range in the following sub-indicator:

- The medical leadership did not complete all 12 clinicians' performance appraisals timely (MIT 15.104, zero). For 12 appraisals, we found one or more of the following deficiencies: the medical leadership failed to provide a completed probation report, complete an annual performance appraisal summary report, or complete a new provider onboarding checklist.

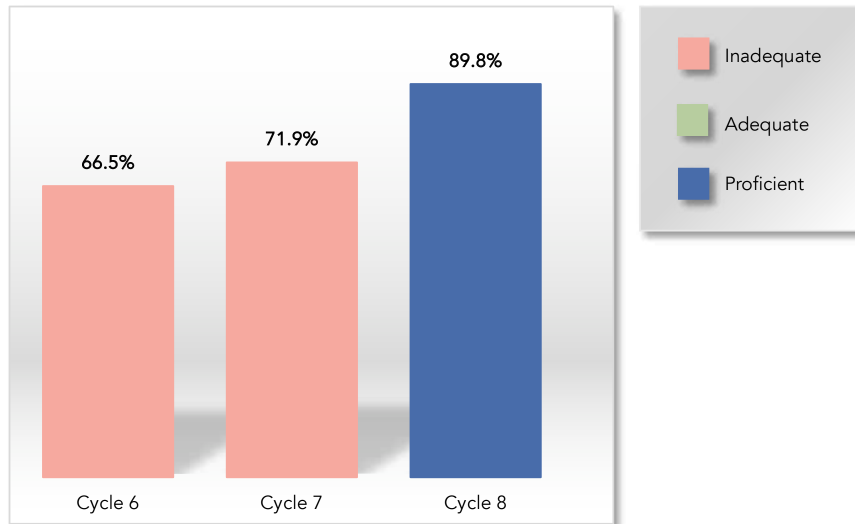
The following test(s) are not scored but are reported for informational purposes:

- At SATF, the institution had two reported adverse sentinel events requiring root cause analysis during our inspection period. For one report, SATF did not report the sentinel event timely as required by CCHCS policy. The other report was submitted nine days late from the required time frame (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 five of nine patient death reports. For the remaining four patient death reports, the compliance date is beyond our testing period (MIT 15.998 [non-scored component], N/A).

Analysis of Performance Across Inspection Cycles

Figure 11. Administrative Operations, Compliance Scores Across Cycles



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

In Cycle 8, SATF 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 89.8 percent in Cycle 8. This reflects significant progress from 66.5 percent in Cycle 6 and 71.9 percent in Cycle 7, demonstrating an outstanding commitment to improvement in this area.

Table 28. Administrative Operations Compliance Test Scores

	Scored Answer			
Compliance Questions	**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)	7	1	0	87.5%
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)	0	12	0	0
Did the providers maintain valid state medical licenses? (15.105)	16	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)	5	0	2	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	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.108)	31	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)	9	0	0	100%
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 3 for CCHCS- provided staffing information.			
Overall percentage (MIT 15): **89.8%**				

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

Compliance Recommendations

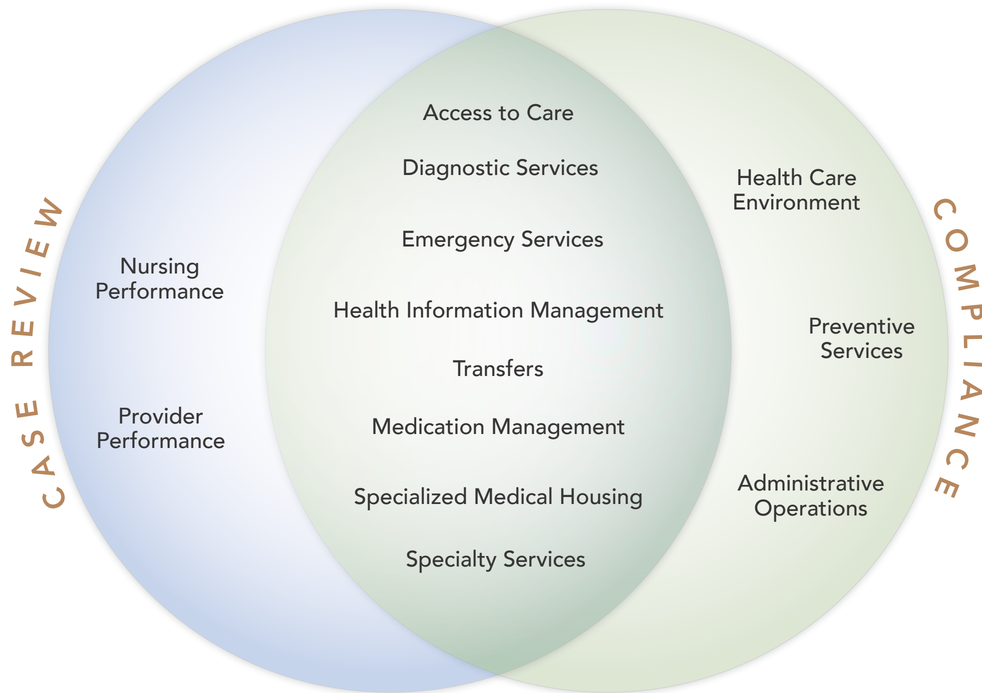
The OIG offers no recommendations for this indicator.

Appendix A: Methodology[93]

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 12 below depicts the intersection of case review and compliance.

Figure 12. Inspection Indicator Review Distribution for SATF



[93] 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 8 medical inspections. Below, Table 29 provides important definitions that describe this process.

Table 29. Case Review Definitions

Term	Definition
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

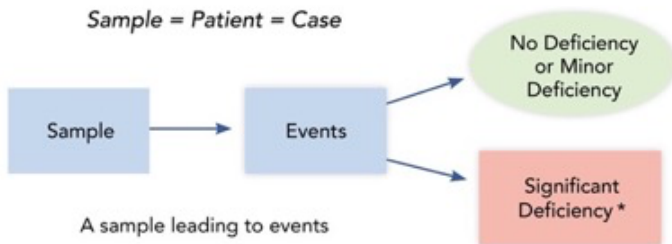
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we 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 13 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.

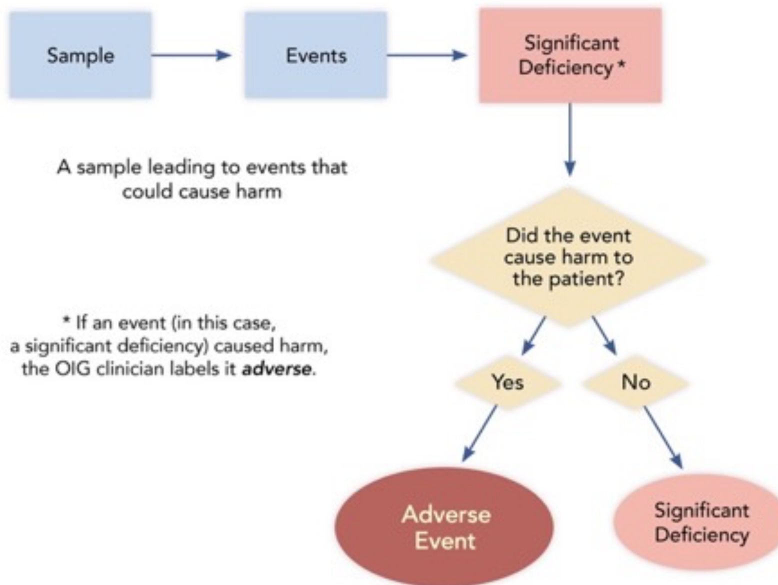
Figure 13. Case Review Testing

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 30. SATF Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	1
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	24
Specialty Services	2
	56

Table 31. SATF Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	9
Anticoagulation	7
Arthritis/Degenerative Joint Disease	7
Asthma	6
COPD	2
Cancer	2
Cardiovascular Disease	6
Chronic Kidney Disease	4
Chronic Pain	8
Cirrhosis/End-State Liver Disease	1
Coccidioidomycosis	4
DVT/PE	1
Diabetes	9
Gastroesophageal Reflux Disease (GERD)	8
Gastrointestinal Bleed	1
Hepatitis C	11
Hyperlipidemia	24
Hypertension	28
Mental Health	27
Seizure Disorder	3
Sleep Apnea	5
Substance Abuse	19
Thyroid Disease	6
	198

Table 32. SATF Case Review Events by Program

Diagnosis	Total
Diagnostic Services	151
Emergency Care	61
Hospitalization	22
Intra-System Transfers In	17
Intra-System Transfers Out	11
Outpatient Care	366
Specialized Medical Housing	75
Specialty Services	114
	817

Table 33. SATF Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	1
RN Reviews Detailed	13
RN Reviews Focused	37
Total Reviews	71
Total Unique Cases	56
Overlapping Reviews (MD & RN)	15

Appendix C: Compliance Sampling Methodology

Substance Abuse Treatment Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	40	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
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (30 days–7 months) • Service (pathology-related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Emergency Services				
MIT 3.001	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MITs 3.101 - 103	Clinical Areas	9	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	40	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 • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Transfers				
MITs 6.001–003	Intra-system Transfers	25	SOMS	• Arrival date (1–7 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	2	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) • Randomize
MIT 7.006	En Route	0	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 7.108–111	Pharmacy	1	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				
MITs 9.001–002	TB Medications	25	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
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	11	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 bus days prior to inspection date) • All
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (1–7 months) • 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, optometry, ophthalmology, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
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	2	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	8	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.103	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.104	Provider Annual Evaluation Packets	12	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	9	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 24, 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 Substance Abuse Treatment Facility. Thank you for preparing the report.

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

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F6B95AC0A4D1...

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

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Sarah Hartmann, Chief Counsel, CCHCS Office of Legal Affairs
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Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
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CALIFORNIA CORRECTIONAL
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P.O. Box 588500
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Cycle 8

Medical Inspection Report

for

Substance Abuse Treatment Facility and State Prison at Corcoran

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2026

OIG