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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

August 2026

California State Prison, Los Angeles County

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. 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 overall case review and compliance 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 compliance testing scores relating to institutional staff preparing for subsequently assessing emergency responses. Thus, to better assess emergency care, we relocated four compliance subindicator 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 California State Prison, Los Angeles County, the institution had been delegated back to the department by the receiver (2024).

We completed our eighth inspection of California State Prison, Los Angeles County, and this report presents our assessment of the health care provided at this institution during the inspection period.[7]

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

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

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

[7] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The general inspection period includes samples from August 2025 to February 9, 2025, as well as on-site observations during March 2026 and April 2026; however, the OIG may review samples outside the general inspection period as dictated by our methodologies. The case reviews include death reviews between February 2025 and December 2025.

Summary: Ratings and Scores

We completed the Cycle 8 inspection of California State Prison, Los Angeles County (LAC), in February 2026. 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 LAC as ***adequate***.

The OIG rated the compliance component of the overall health care quality at LAC as ***adequate*** (**77.1%**).

OIG case review clinicians—a team of Physicians & Surgeons (physicians) and Nursing Consultants, Program Review (NCPRs)—reviewed 60 cases, which contained 1,046 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 April 2026 to verify their initial findings. OIG clinicians evaluated the quality of care for a total of 60 case reviews that included both physician and NCPR comprehensive detailed case reviews and focused case event reviews.[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 concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.

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

[8] For our detailed and focused case reviews, our clinicians reviewed medical charts and events for 60 unique patients. Both physicians and NCPRs reviewed 20 of those cases, for a total of 80 detailed and focused case reviews.

department's Health Care Department Operations Manual (HCDOM)[9] 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 402 patient records and 1,207 data points, and we used the data to assess 98 MIT questions. We also observed LAC's processes during an on-site inspection in March 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.[10]

Overall Medical Inspection Results

Case Review Results

OIG case reviewers assessed 10 of the 13 indicators applicable to LAC. OIG clinicians rated one of these 10 indicators proficient, eight adequate, and one inadequate. In the 1,046 events reviewed, we identified 267 deficiencies, 71 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm. We solely tested Nursing Performance and Provider Performance in clinical case review as these indicators do not have a compliance component.

Adverse Events Identified During Case Review

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

Compliance Testing Results

Our compliance inspectors assessed 11 of the 13 indicators applicable to LAC. Of these 11 indicators, our compliance inspectors rated four ***proficient***, four ***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 below.

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

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

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

MIT Number	Health Care Indicators	Case Review Ratings: Cycle 8	Case Review Ratings: Change Since Cycle 7*	Compliance Scoring Ranges: Cycle 8	Compliance Scoring Ranges: Cycle 7	Compliance Scoring Ranges: Change Since Cycle 7*
		Ratings: Proficient, Adequate, Inadequate		*Scoring Ranges*: 100%–85.0%, 84.9%–75.0%, 74.9%–0		
		Case Review		Compliance		
1	Access to Care	Proficient	↑	77.0%	81.5%	=
2	Diagnostic Services	Adequate	↑	84.4%	62.2%	↑
3	Emergency Services	Adequate	↑	39.1%	N/A	N/A
4	Health Information Management	Adequate	=	90.9%	85.0%	=
5	Health Care Environment	N/A	N/A	86.6%	37.9%	↑↑
6	Transfers	Adequate	=	88.5%	78.3%	↑
7	Medication Management	Adequate	↑	73.9%	55.4%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	91.7%	58.9%	↑↑
10	Nursing Performance	Adequate	↑	N/A	N/A	N/A
11	Provider Performance	Adequate	=	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Inadequate	=	57.1%	62.0%	=
14	Specialty Services	Adequate	↑	77.5%	49.2%	↑
15	Administrative Operations	N/A	N/A	81.4%	70.4%	↑

* 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, and the double arrow means the rating rose or fell two levels (green, from inadequate to proficient; pink, from proficient to inadequate).

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

Institution-Specific Metrics

California State Prison, Los Angeles County (LAC), houses more than 3,144 patients and is located in the city of Lancaster. The institution has been designated as an *intermediate care prison*, which responds to nonurgent requests for medical services and provides an enhanced outpatient program. The institution conducts patient screenings in its receiving and release (R&R) clinical area, treats patients who require urgent or immediate care in its triage and treatment area (TTA), and treats patients who require inpatient care in its correctional treatment center (CTC).[11]

On January 12, 2026, the Health Care Services Master Registry showed LAC had a total population of 3,144. A breakdown of the medical risk level of the LAC population as determined by the department is set forth in Table 2 below.[12]

Table 2. LAC Master Registry Data as of January 2026

Medical Risk Level	Number of Patients	Percentage*
High 1	399	12.7%
High 2	489	15.6%
Medium	1,675	53.3%
Low	581	18.5%
Total	**3,144**	**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 January 12, 2026.

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

[12] 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, LAC had no vacant executive leadership positions, 2.5 primary care provider vacancies, 1.2 nursing supervisor vacancies, and 31.1 nursing staff vacancies.

Table 3. LAC Health Care Staffing Resources as of January 2026

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	4.0	11.5	20.2	190.7	226.4
Filled by Civil Service	4.0	9.0	19.0	159.6	191.6
Vacant	0.0	2.5	1.2	31.1	34.8
Percentage Filled by Civil Service	100.0%	78.3%	94.1%	83.7%	84.6%
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	2.0	0.0	28.0	30.0
Percentage Filled by Registry	0.0%	17.4%	0.0%	14.7%	13.3%
Total Filled Positions	4.0	11.0	19.0	187.6	221.6
Total Percentage Filled	100.0%	95.7%	94.1%	98.4%	97.9%
Appointments in Last 12 Months	0.0	1.0	6.0	50.0	57.0
Redirected Staff	0.0	0.0	0.0	4.0	4.0
Staff on Extended Leave‡	0.0	0.0	3.0	8.0	11.0
Adjusted Total: Filled Positions	4.0	11.0	16.0	175.6	206.6
Adjusted Total: Percentage Filled	100.0%	95.7%	79.2%	92.1%	91.3%

* 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 January 12, 2026, 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 HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered LAC'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 Permanente LAC'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. LAC had a 21 percent influenza immunization rate for adults 18 to 64 years old and a 46 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal immunization rate was 78 percent.

Cancer Screening

Statewide comparative data was available for colorectal cancer screening. When compared with statewide programs—California Medi-Cal and Kaiser Permanente—LAC had a 76 percent colorectal cancer screening rate, a rate higher and thus better than California Medi-Cal, but lower than Kaiser Permanente.

Table 4. LAC Results Compared to State HEDIS Scores

HEDIS Measure	LAC Cycle 8 Results*	California Medi-Cal†	Kaiser Permanente†
Poor HbA1c Control (>9.0%) ‡, §	**7%**	29%	20%
HbA1c Control (<8.0%) ‡	87%	–	–
Blood Pressure Control (<140/90) ‡	91%	–	–
HbA1c Screening	100%	–	–
Eye Exams	34%	–	–
Influenza - Adults (18–64)	21%	–	–
Influenza - Adults (65+)	46%	–	–
Pneumococcal – Adults (65+)	78%	–	–
Colorectal Cancer Screening	76%	40%	**79%**

* Unless otherwise stated, data were collected in February 2026 by reviewing medical records from a sample of LAC'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 Contract Year 2024-2025 (published April 2026); https://www.dhcs.ca.gov/wp-content/uploads/2026/05/CA2024-25-MCMC-PH-EQR-TR-Vol1-F1.pdf

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

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

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

Access to Care

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

Access to Care: Case Review Ratings and Results Summary

In this cycle, case review found LAC performed exceptionally well in delivering access to care for its patients. Providers timely evaluated patients in the outpatient clinics and specialized medical housing. Follow-up appointments after hospitalizations, specialty appointments, emergency events, and transferring into LAC occurred timely. Some opportunities for improvement related to providing access to clinic nurses and to specialists. After considering all factors, the OIG rated the case review component of this indicator ***proficient.***

Case Review Results

Table 5. Case Review Access to Care Results

Total Cases Reviewed*	Deficiencies†	Significant Deficiencies‡
60	12	4

* The OIG reviewed 60 cases.

† Deficiencies occurred in cases 1, 9, 13, 18–19, 21–22, 51, 52, 53, and 60. Of these 12 deficiencies, five related to specialty services appointments and seven related to outpatient clinic appointments.

‡ Significant deficiencies occurred in cases 1, 13, and 19.

Performed Well

OIG clinicians found LAC performed well with no deficiencies in all the following areas:

- Access to Clinic Providers
- Access to Specialized Medical Housing Providers
- Follow-up After Specialty Services
- Follow-up After Hospitalizations
- Follow-up After Urgent and Emergent Care
- Follow-up After Transferring into LAC

Performed Satisfactorily, with Opportunities for Improvement

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

- Access to Clinic Nurses

  LAC clinic nurses often assessed patients timely; however, we identified seven deficiencies, one of which was significant.[13] The following are examples:

  - In case 18, the RN assessed the patient for complaints of changes in his mental capacity and balance. The nurse documented in the plan of care for a provider 14-day follow-up appointment; however, the nurse did not order the follow-up appointment as documented.
  - In case 19, LAC staff evaluated the patient in the TTA for significantly elevated blood pressure and ordered blood pressure checks to occur daily for the next five days. However, the patient did not receive blood pressure checks until four days later.
  - In case 21, the clinic nurse assessed the patient for left ear pain and co-consulted with the provider. The provider evaluated the patient and ordered antibiotics and ibuprofen. The clinic nurse documented in the notes "follow up to clinic RN: within 14 calendar days." However, we found no evidence in the EHRS the appointment was scheduled.[14]

[13] Deficiencies occurred in cases 9, 18-19, 21, 51, and 53. One significant deficiency occurred in case 19.

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

- Access to Specialty Services

  LAC generally performed well in specialty services access; however, OIG clinicians identified five deficiencies, three of which were significant.[15] The following are examples of the significant deficiencies:

  - In case 1, the provider requested an infectious disease specialty telemedicine appointment, but the appointment did not occur.
  - Also in case 1, the provider requested a referral for a cystoscopy because the patient had blood in his urine.[16] However, the appointment did not occur.
  - In case 13, the provider ordered the patient to have a pacemaker check on the same day, but this check did not occur.

Performed Poorly, Improvement Needed

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

Clinician On-Site Inspection

LAC leadership reported LAC has five primary clinics, identified as Clinics A, B, C, and D, as well as a Restricted Housing Unit (RHU) clinic and a Minimum Support Facility (MSF) clinic. Staff at each of the four main clinics includes one office technician, four RNs, and two medical providers, while the RHU and MSF clinics each have one medical provider. The office technicians coordinate and bundle provider appointments to improve scheduling efficiency. Each provider evaluated, on average, approximately 10 to 12 patients per day. During the onsite inspection, leadership reported no provider or nursing appointment backlogs in any of the clinics.

Photo 1. Entrance to Clinic C.
Photographed on 4-22-2026.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

[15] Deficiencies occurred in cases 1, 13, 22, and 60. Significant deficiencies occurred in cases 1 and 13.

[16] A cystoscopy is a procedure in which a specialist uses a tube with a camera to examine the bladder and urinary tract.

Access to Care: Compliance Ratings and Results Summary

Compliance Rating

ADEQUATE

Compliance Score

(77.0%)

LAC performed satisfactorily in this indicator. Based on the overall compliance score result of 77.0 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- The institution performed exceptionally and ensured the most recent chronic care appointments were conducted within the specified timeframe for 23 of 25 sampled patients (MIT 1.001, 92.0%). For two patients, the record contained no evidence the appointment occurred, or the record contained no evidence a refusal form was completed during our review period.

- When new patients arrive at the institution, they must either be assessed by an RN or evaluated by a provider, depending on their clinical risk level. Among the 25 patients we sampled, providers maintained their workflows and completed their comprehensive patient appointments for all 25 patients referred for provider appointment. (MIT 1.002, 100%).

- Following the review of patients' submitted health care service request forms (CDCR form 7362s), RNs timely completed face-to-face appointments for 27 of 28 sampled patients within one business day (MIT 1.004, 96.4%). For one patient, the appointment occurred one day late.

- Providers timely completed post-discharge follow-up appointments for 23 of 25 sampled patients within the required timeframe (MIT 1.007, 92.0%). For two patients, the appointments occurred between one and two days late.

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

- The institution usually 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 primary care team provided the required timely notification of the specialist's recommendations for 32 of 38 sampled patients (MIT 1.008, 82.2%). For four patients, the primary care provider (PCP) follow-up appointment after a high-priority specialty service occurred between seven and eight days late. For three patients, the record contained no evidence of a PCP appointment following a high-priority specialty service within our review period. For the remaining one patient, the record contained no evidence a refusal form for a follow-up after a medium-priority specialty service was completed during our review period.

- The institution implemented a standardized process for the acquisition and submission of CDCR form 7362s for five of six housing units (MIT 1.101.2, 83.3%). For one housing unit, custody staff did not have a supply of CDCR form 7362s available at the time of our inspection.

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

- Nursing staff performed poorly in adhering to triage documentation standards; the institution met the full requirements for a completed review upon receipt of the health care service request form for only three of 30 sampled patients (CDCR form 7362) (MIT 1.003, 10.0%). For 27 patients, nursing staff failed to accurately complete the CDCR form 7362 with the required receipt date and time, their printed or stamped name, and their title.

- Among 10 applicable samples in which an RN identified the need for a primary care referral, only five patients were seen within the required timeframe according to the priority level assigned to their appointment (MIT 1.005, 60.0%). For two patients, the record contained no evidence the appointment occurred during our review period. For two patients, the appointments occurred three and 12 days late.

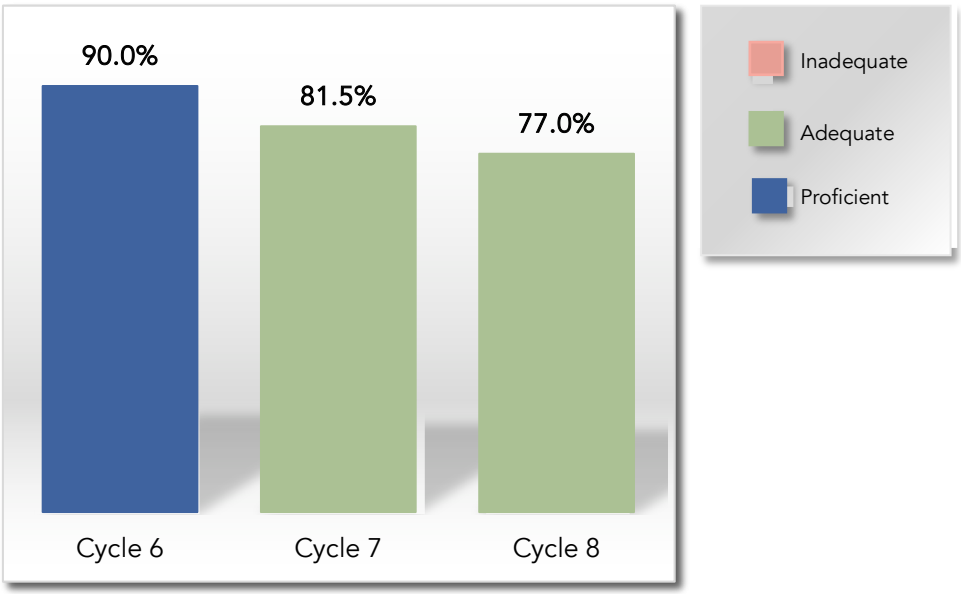
The following tests are not scored but are reported for informational purposes:

- The institution implemented a standardized process for replenishing CDCR form 7362s, whereby custody officers coordinate through the program office to ensure they maintain an adequate supply for all patients. However, one housing unit continued to rely on medical staff to replenish these forms (MIT 1.101.1, N/A).

- We deemed the compliance test MIT 1.006 not applicable during the reporting period because no qualifying follow-up provider sick call appointments requiring evaluation occurred (MIT 1.006, N/A).

Analysis of Performance Across Inspection Cycles

Figure 1. Access to Care, Compliance Scores Across Cycles



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

LAC met the 75.0 percent passing compliance threshold in this indicator, maintaining an adequate performance of 77.0 percent in Cycle 8. While this score places LAC's performance in the adequate range, this score follows LAC's previous proficient score of 90.0 percent in Cycle 6 and higher adequate score of 81.5 in Cycle 7. The current score represents some regression from previous cycles, indicating the institution's performance is trending closer to the minimum 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)	23	2	0	92.0%
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)	25	0	0	100%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	3	27	0	10.0%
Clinical appointments: Did the registered nurse complete a face-to- face visit within one business day after the CDCR form 7362 was reviewed? (1.004)	27	1	2	96.4%
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)	6	4	20	60.0%
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)	0	0	30	N/A
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	23	2	0	92.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? For medium- or routine-priority specialty service appointments: If the patient was not seen, did the PCT inform the patient of the recommendations within the required time frame? (1.008)	37	8	0	82.2%
For informational purposes only: Do custody staff members have a system in place to replenish health care services request forms? (1.101.1)	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)	5	1	0	83.3%
			Overall percentage (MIT 1):	**77.0%**

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 7362s) and complete all required documentation. Leadership should implement and monitor remedial measures as appropriate.
- Health care leadership should determine the challenges to facilitating timely nurse-to-provider referrals. Leadership should implement and monitor remedial measures as appropriate.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the test reports and whether providers reviewed the results timely.

Diagnostic Services: Case Review Ratings and Results Summary

In this cycle, case review found LAC performed satisfactorily with diagnostic services. LAC staff almost always completed diagnostic tests timely. However, similar to during Cycle 7, providers often either did not send test result notification letters or sent incomplete letters to patients. After considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 7. Case Review Diagnostic Services Results

Diagnostic Events*	Deficiencies†	Significant Deficiencies‡
146	37	2

* The OIG reviewed 146 events.

† Deficiencies occurred in cases 1–3, 6, 7, 9 10, 12–14, 16, 19–26, and 59. Of these 37 deficiencies, 35 related to patient results notification letters, one related to a provider's review of a test, one related to late record scanning, and one related to delay in a diagnostic test completion.

‡ Significant deficiencies occurred in cases 1 and 13.

Performed Well

OIG clinicians found LAC performed well in the following area:

- Test Completion[17]

[17] A significant deficiency with an outpatient test completion occurred in case 1. The test was completed during a hospitalization.

Performed Satisfactorily with Opportunities for Improvement

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

Performed Poorly, Improvement Needed

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

- Health Information Management[18]

  Most of the diagnostic deficiencies related to health information management. We identified 36 deficiencies, one of which was significant. The deficiencies related to incomplete or missing test result notification letters to patients, a late record scan, and a provider's review of test results. The following are examples:

  - In case 13, sub-therapeutic INR results were available for review.[19] However, neither the ordering provider nor the covering provider endorsed these laboratory test results, and the warfarin (blood-thinner) doses were not adjusted to therapeutic levels.

  - In case 59, the provider endorsed the laboratory test results. However, the provider did not create a patient test result notification letter.

[18] Deficiencies occurred in cases 1–3, 6, 7, 9, 10, 12–14, 16, 19–26, and 59. Significant deficiencies occurred in cases 13.

[19] 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.

Clinician On-Site Inspection

We spoke with the senior laboratory technologist and inspected the diagnostic areas. The senior laboratory technologist reported LAC employs six full-time laboratory technologists, and each technologist collects approximately 40 blood or urine samples daily. LAC also has one full-time radiologic technologist (RT) and one part-time RT who perform basic on-site x-rays. In addition, LAC offers mobile CT, ultrasound, and MRI services every two weeks.[20] At the time of the inspection, LAC informed us they had no staffing shortages in either the laboratory or radiology departments.

Photo 2. Radiology room equipment. Photographed on 4-22-2026.

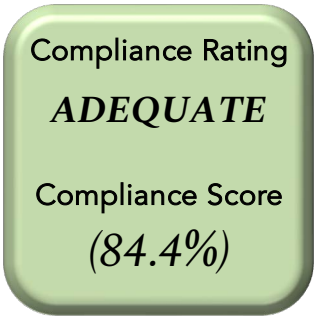
According to the senior laboratory technologist, LAC laboratory staff use an application to monitor laboratory tests from the time they are ordered until completion. If a patient refuses a laboratory test, the technologist documents the date and time of the refusal in the application's comment section and forwards the information to the provider. The senior laboratory technologist also tracks pathology specimens collected at LAC and works with the health information management supervisor to obtain, retrieve, and scan pending pathology reports into the EHRS.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

[20] 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.

Diagnostic Services: Compliance Ratings and Results Summary



LAC performed well in this indicator. Based on the overall compliance score result of 84.4 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- The institution's radiology department delivered excellent diagnostic services for all 10 sampled patients within required timeframes (MIT 2.001, 100%).
- Providers demonstrated proficiency in reviewing and endorsing radiology reports for all 10 sampled patients (MIT 2.002, 100%).
- Laboratory services consistently completed orders for nine of 10 sampled patients within the timeframes specified (MIT 2.004, 90.0%). For one patient, the laboratory services ordered as timed studies were not performed within the specified timeframes.
- Providers demonstrated proficiency in timely reviewing and endorsing laboratory reports for all 10 sampled patients (MIT 2.005, 100%).
- LAC received pathology reports for all 10 sampled patients within required timeframes (MIT 2.010, 100%).
- Providers demonstrated proficiency in timely reviewing and endorsing pathology reports for all 10 sampled patients (MIT 2.011, 100%).

LAC 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 timeframes for six of 10 sampled patients (MIT 2.003, 60.0%). For four patients, the patient letters were missing key elements as required by policy.
- Healthcare providers generated patient notification letters for laboratory reports with all required elements within specified timeframes for seven of 10 sampled patients (MIT

2.006, 70.0%). For three patients, the patient letters were missing key elements as required by policy.

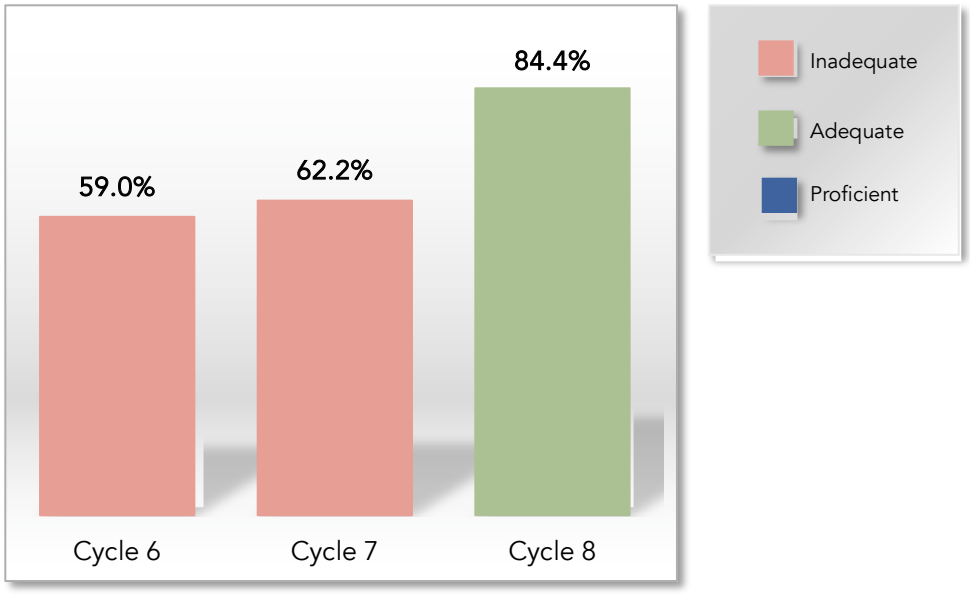
- Healthcare providers generated a patient notification letter for pathology laboratory results within specified timeframes for only four of 10 sampled patients (MIT 2.012, 40.0%). For five patients, the patient letters were missing key elements as required by policy. For the remaining patient, the record contained no evidence of a generated patient letter communicating pathology results.

The following tests are not scored but are reported for informational purposes:

- The compliance tests for MITs 2.007, 2.008, and 2.009 in this indicator were deemed not applicable during the reporting period as no qualifying patients with stat (immediate) laboratory orders required evaluation (MIT 2.007, MIT 2.008, & MIT 2.009, N/A).

Analysis of Performance Across Inspection Cycles

Figure 2. Diagnostic Services, Compliance Scores Across Cycles



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

Overall, the institution met the 75.0 percent passing compliance threshold for diagnostic services, reaching 84.4 percent in Cycle 8. This performance demonstrates significant steady improvement over the past three cycles in this indicator from inadequate scores of 59.0 percent in Cycle 6 and 62.2 percent in Cycle 7, to a nearly proficient score in this cycle.

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)	10	0	0	100%
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)	6	4	0	60.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	9	1	0	90.0%
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)	7	3	0	70.0%
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)	4	6	0	40.0%
				Overall percentage (MIT 2): **84.4%**

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

Compliance Recommendations

- The department should develop, implement, and monitor solutions, such as an electronic solution, to ensure providers timely communicate radiology, laboratory, and pathology results to 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.

Additionally, for the first time in this cycle, the **Emergency Services** indicator had a compliance inspection component. Specifically, as discussed further in both the Introduction and below in the **Analysis of Performance Across Inspection Cycles** section of this indicator, the OIG identified a cross-institution correlation in Cycle 7 between low institution case review ratings for emergency services and low compliance scores in four compliance tests measuring varying requirements for emergency response preparation, emergency supply management, and post-emergency reviews, all of which we previously tested under other indicators. To better highlight institutional performances for medical emergencies, we relocated these four tests into a new compliance component of the **Emergency Services** indicator.

Emergency Services: Case Review Ratings and Results Summary

In this cycle, case review found LAC performed satisfactorily with emergency responses. LAC custody staff promptly activated medical alarms, initiated CPR, and administered naloxone for unresponsive patients. Nursing staff responded immediately to medical alarms, assessed patients, and consulted the providers when appropriate. Medical and nursing leadership performed clinical reviews and usually identified deficiencies similar to OIG findings during unscheduled transfers to the community hospital. Our clinicians did not identify any significant patterns of deficiencies. Although the number of deficiencies was high relative to the number of cases, most of the deficiencies identified did not affect the care staff provided to the patient. However, we identified opportunities for improvement in ensuring nursing staff perform thorough assessments and documentation in emergency events. Considering all factors, the OIG rated this indicator ***adequate***.

Case Review Results

Table 9. Case Review Emergency Services Results

Urgent or Emergent Events*	Deficiencies†	Significant Deficiencies‡
39	32	5

* We reviewed 39 urgent or emergent events occurred in cases 1–10, 17, and 19–23.

† Deficiencies occurred in cases 1–3, 5, 6, 8, 9, 14, 17, 19, 20, 22, and 25. One of these deficiencies occurred in one case related to missing automated external defibrillator (AED) log and CPR record that was not scanned into the EHRS,[21] seven related to clinical reviews, 10 related to provider performance, and 14 related to nursing performance.

‡ Significant deficiencies occurred in cases 14, 17, 19, and 22.

Performed Well

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

Performed Satisfactorily, with Opportunities for Improvement

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

- Emergency Medical Response

  LAC staff responded promptly to medical emergencies and almost always transported the patients to TTA timely. However, the OIG clinicians identified one case in which LAC staff did not timely activate emergency medical services (EMS). This significant deficiency is below:

  - In case 17, custody activated a medical alarm for a suspected overdose. Custody staff administered a first dose of naloxone and the LVN administered a second

[21] An automated external defibrillator (AED) is a portable device that can help restore a normal heart rhythm in a patient in cardiac arrest.

dose of naloxone with no impact. [22] However, LAC staff did not contact EMS for six minutes after the healthcare responders arrived to the scene.[23]

- Cardiopulmonary Resuscitation Quality

  Our clinicians reviewed six CPR cases and identified six deficiencies, none of which were significant.[24] We found custody and nursing staff promptly initiated CPR and administered naloxone when required. Nursing staff generally provided appropriate assessments and interventions. However, we found opportunities for improvement in assessments and documentation. The following are examples:

  - In case 5, custody activated a medical alarm for an unconscious patient with a suspected drug overdose. Custody staff administered naloxone. The LVN noted the unconscious patient had labored breathing with an irregular heart rhythm. However, though this patient had a pulse with an irregular heart rhythm, the LVN initiated CPR but did not check the patient's respiratory rate. The RN arrived to the patient, found the patient with a pulse, and discontinued CPR. Additionally, when the patient was in the TTA, the provider ordered an EKG for an elevated heart rate. However, nursing staff did not perform the EKG.[25] This patient refused transfer to the community hospital. After educating the patient, the provider ordered the nurses to monitor the patient in the TTA prior to discharge to the housing unit.

  - In case 6, custody activated a medical alarm for an unconscious patient on the yard. Healthcare staff responded and provided appropriate interventions. Upon arrival to the TTA, the patient did not have a pulse and nurses promptly initiated CPR. However, the first medical responders did not document the patient's pulse rate and rhythm, pulse pressure, and respiratory rate. Additionally, we identified documentation discrepancies in the timeline indicating when the first healthcare responder arrived on the scene as well as documentation discrepancies in the method of oxygen delivery. The LVN documented oxygen via nasal cannula; however, documentation also shows the patient was started on oxygen via a

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

[23] According to the American Heart Association's 2025 guidelines on basic lifesaving care, when a patient is initially found unresponsive, the first step is to initiate EMS before taking any further lifesaving steps. (See https://cpr.heart.org/-/media/CPR-Images/CPR-Guidelines-2025/Algorithms/Figure-2-Adult-BLS-Algorithm-for-Lay-Rescuers.jpg?h=1789&w=1200&sc_lang=en&hash=D3971447C64EFFEAB8A87346C711BB57.) In this case, the health care responders should have initiated EMS immediately upon arriving to the patient and learning that custody discovered the patient unresponsive and already initiated a dose of Narcan.

[24] CPR occurred in cases 4–9. Deficiencies occurred in cases 5, 6, and 8. No significant deficiencies occurred.

[25] 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.

nonrebreather mask.[26] Moreover, the TTA nurses did not assess the patient's central pulse during CPR after delivering AED shocks.

- In case 8, custody activated a medical alarm for an unresponsive patient with suspected overdose and promptly initiated CPR, administered naloxone, and called EMS. Nursing staff promptly responded, applied the AED, and administered one dose of naloxone. However, nursing staff did not check the patient's blood sugar or administer additional doses of naloxone. CPR efforts continued until the paramedics arrived and pronounced the patient's death.

- Nursing Performance in Assessments and Interventions

  Our clinicians found nurses generally provided good care in urgent and emergent events. We identified 14 nursing performance deficiencies, one of which was significant.[27] Of these 14 deficiencies, three occurred in the CPR cases, none of which were significant.[28] We identified no specific trends. The following are examples of deficiencies in emergency nursing assessments and interventions:

  - In case 3, custody staff activated a medical alarm for a patient with a suspected overdose. Healthcare staff promptly arrived and administered two doses of naloxone with improvement noted. The patient became alert and was transported to the TTA. The patient had an elevated blood pressure and pulse. However, the first healthcare responders did not obtain vital signs. Secondly, the TTA RN did not reassess the patient's elevated blood pressure and pulse while in the TTA.

  - In case 19, the patient reported to the medication area to pick up medication to treat high cholesterol. The patient reported to the LVN symptoms of chest pain and reported a history of a blood clot in the chest. The LVN obtained vital signs and recorded a significantly elevated blood pressure reading. However, the nursing documentation of the timeline of the events was unclear. The RN noted the patient arrived to the TTA five minutes prior to the time the medication was administered at the medication area. Additionally, the LVN did not ensure medical staff accompanied the patient to TTA with symptoms of chest pain and an elevated blood pressure. Instead, custody staff escorted the patient to the TTA. Moreover, the TTA RN administered the first dose of blood pressure medication to lower the patient's blood pressure. Approximately one hour later, the nurse administered a second dose of blood pressure medication. However, the RN did

[26] A nasal cannula is a flexible plastic tube that delivers oxygen directly into the nose. A non-rebreather mask is an oxygen mask that delivers high concentrations of oxygen and is used when person can breathe on their own but needs a lot of oxygen quicky.

[27] Nursing performance deficiencies occurred in cases 1–3, 5, 6, 8, 9, 17, 19, and 20. A significant deficiency occurred in case 17.

[28] CPR nursing performance deficiencies, none of which were significant, occurred in cases 5, 6, and 8.

not reassess vital signs before administering the second dose or prior to discharging the patient to the housing unit.

- Nursing Documentation[29]

  LAC nurses usually documented thoroughly. As noted above, we identified some documentation discrepancies in CPR cases.

- Emergency Medical Response Review Process

  LAC performed adequately overall in reviewing unscheduled transports to higher level of care. Our clinicians identified seven deficiencies, none which were significant.[30]

- Provider Performance

  LAC providers performed acceptably overall in urgent and emergent situations as well as after-hours care. The institution provided emergency coverage within the TTA. OIG clinicians identified 10 deficiencies, four of which were significant.[31] OIG clinicians identified a minor pattern of providers not documenting a progress note for patients evaluated in the TTA or who transferred to a community hospital.[32] However, we determined these omissions did not significantly impact care based on the orders and appropriate patient disposition from the providers. LAC providers generally made good decisions for patients who presented with acute symptoms or were transferred to a community hospital.[33] Additionally, providers usually transferred patients to a community hospital through the appropriate mode of transportation. The following are examples of missing provider documentation and questionable decision making:

  - In case 14, the nurse informed the provider of a diabetic patient with hypoglycemia. The provider ordered monitoring within the TTA for one hour and discharged the patient back to the yard. However, the provider did not document a progress note to explain their assessment.

  - In case 22, a provider sent the patient with a history of stage IV lung cancer (receiving chemotherapy) to the TTA for evaluation of anemia and

[29] Documentation discrepancies occurred in cases 1, 6, 8, and 19.

[30] Deficiencies occurred in cases 1, 2, 6, 8, and 22. No significant deficiencies occurred.

[31] Deficiencies occurred in cases 1, 2, 14, 17, 19, 22, and 25. Significant deficiencies occurred in cases 14, 17, 19, and 22.

[32] Provider documentation deficiencies occurred in cases 1, 2, 14, 17, 19, and 25. Significant deficiencies occurred in cases 14, 17, and 19.

[33] Deficiencies with medical decision-making within emergent settings occurred in cases 1, 14, and 22. Significant occurred in cases 14 and 22.

thrombocytopenia.[34] The provider ordered a CBC for two days later when this should have been ordered more urgently.

Performed Poorly, Improvement Needed

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

Clinician On-Site Inspection

The OIG clinicians inspected the TTA, which contained four rooms, called standard bays. The TTA is staffed with two RNs who responded to medical alarms and assessed patients returning from community hospitals and specialist appointments. However, during the day and evening shifts, the nurses in the yards serve as the first healthcare responders and, when requested, the TTA RN responds via an emergency medical van or golf cart. The RNs also indicated, when CTC patients returned after a community specialist appointment or hospital admission, they usually bypassed the TTA and returned directly to the CTC. The RNs further shared, on business days, a provider was available in the TTA. This provider reconciled community provider recommendations and provided urgent and emergent care. Outside of business hours, a provider was available by phone.

Photo 3. TTA Standard Bay. Photographed on 4-22-2026.

Case Review Recommendations

- Nursing leadership should develop, implement, and monitor strategies to ensure nurses perform complete emergency assessments and documentation. Leadership should implement and monitor remedial measures as appropriate.

[34] Anemia is a low red blood cell count, and thrombocytopenia is a low platelet count. Patients receiving chemotherapy are at risk for symptomatic reductions of these cells, which may require urgent evaluation including transfusions.

Emergency Services: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(39.1%)

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

Compliance Testing Results

LAC performed in the ***proficient*** range in the following sub-indicator:

- LAC 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%).

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

- The Emergency Medical Response Review Committee (EMRRC) did not review cases in a timely manner and failed to ensure incident packages included all required documents for seven of 12 sampled patients (MIT 3.001, 58.3%). For five patients, we found one or more of the following deficiencies: the institution did not review the cases timely or the emergency medical response review event checklists were incomplete.

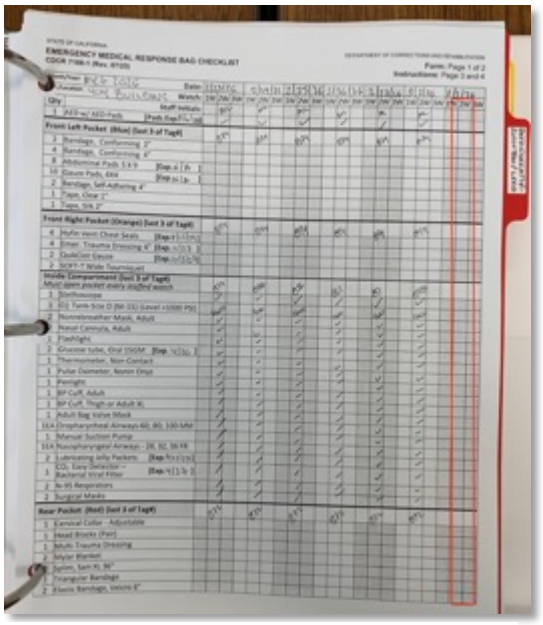


Photo 4. Incomplete EMRB checklist log. Photographed 3-9-2026.

- Nursing staff inspected and inventoried emergency medical response bags (EMRB) and ensured they contained all essential items for only three of the seven applicable clinical areas (MIT 3.101, 42.9%). For four EMRBs, we found one or more of the following deficiencies: staff failed to ensure EMRB compartments were sealed and intact (see Photo 4, above right); and one EMRB daily glucometer quality control log was inaccurate.

- Nursing staff failed to inspect and inventory treatment carts within the required timeframes for either of the two applicable clinical areas (MIT 3.102, zero). For both treatment carts, we found the following deficiencies: 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 5, right).

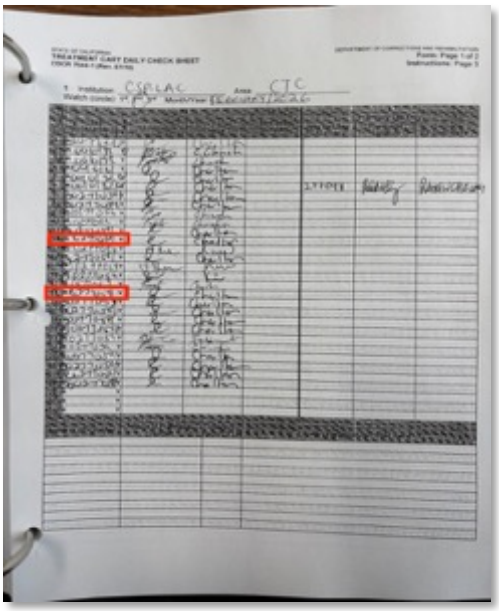


Photo 5. Incomplete treatment cart seal security check log documentation. Photographed 3-9-2026.

- Nursing staff properly inspected and inventoried disaster response bags within the required timeframes for only one of three applicable clinical areas (MIT 3.103, 33.3%). For two locations, although nursing staff provided evidence of monthly inventory check, the log lacked complete documentation of a full inventory (see Photo 6, below left). Specifically, nursing staff failed to place a checkmark in the appropriate boxes to reflect inventory verification.

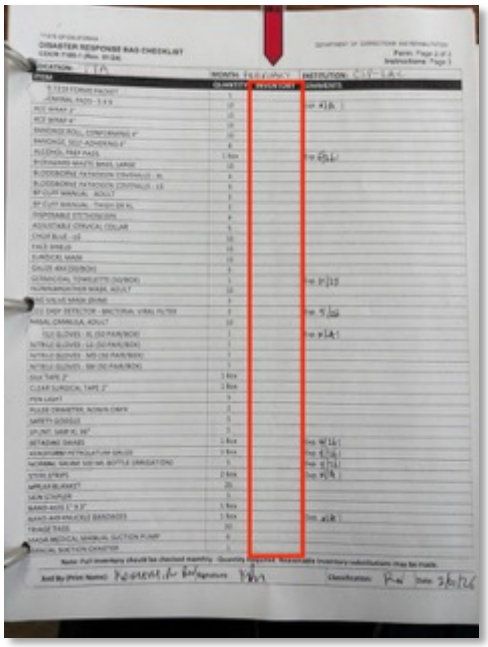
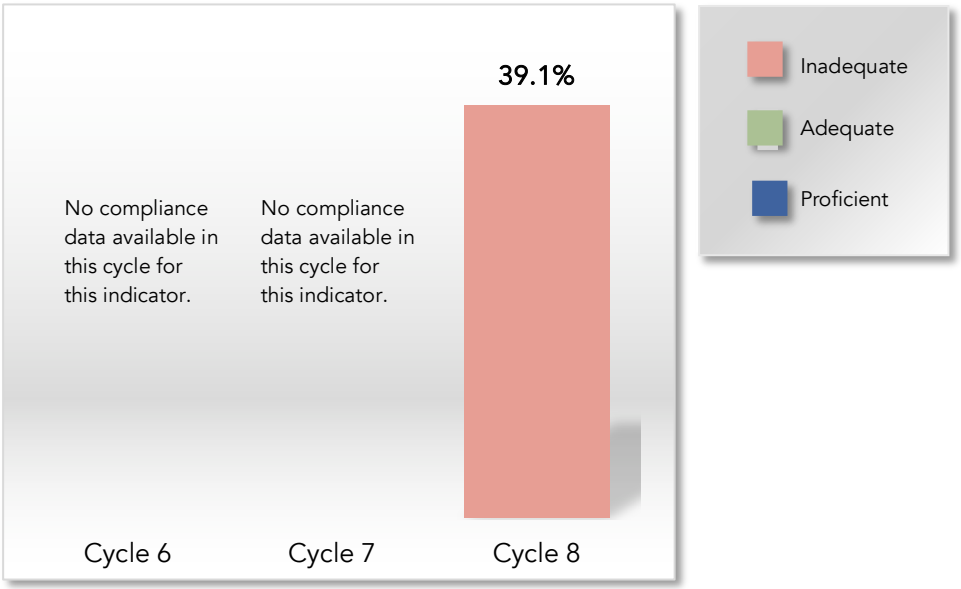


Photo 6. Incomplete inventory documentation of the disaster response log. Photographed 3-9-2026.

- 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). Three of the submitted packets lacked required documentation for the emergency drills performed. Specifically, the institution did not provide the Cardiopulmonary Resuscitation Record (CDCR 7462-1) or the Primary and Secondary Assessment progress notes.

Analysis of Performance Across Inspection Cycles

Figure 3. Emergency Services, Compliance Scores Across Cycles



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

The institution performed below established standards for emergency response and coordination, highlighting significant opportunities for improvement. Specifically, the institution did not meet the 75.0 percent passing compliance threshold for emergency services readiness, reaching only 39.1 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, improvements in MITs 3.001 and 3.101, regression in MIT 3.102, and continuing poor scores in MIT 3.104.

Table 10. Emergency Services Compliance Scores Across Cycles by Test

Cycle 8 MIT Test Number	*Cycle 6 Scores*	*Cycle 7 Scores*	*Cycle 8 Scores*
MIT 3.001	25.0%	0.0%	58.3%
MIT 3.101 & 3.102	11.0%	14.3%	MIT 3.101 42.9% MIT 3.102 0.0%
MIT 3.104	0.0%	0.0%	0.0%
MIT 3.105	100%	100%	100%

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

Table 11. Emergency Services Compliance Test Scores

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the case timely, and did the incident packages reviewed include the required documents? (3.001)	7	5	0	58.3%
Clinical areas: Are emergency medical response bags inspected and inventoried within required timeframes, and do they contain essential items? (3.101)	3	4	3	42.9%
Clinical areas: Are treatment carts inspected and inventoried within required timeframes? (3.102)	0	2	8	0
Clinical areas: Are disaster response bags inspected and inventoried within required timeframes? (3.103)	1	2	7	33.3%
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): **39.1%**

Compliance Recommendations

- Nursing leadership should develop, implement, and monitor strategies to ensure nursing supervisors timely review emergency medical response incidents and thoroughly complete the emergency medical response review checklists as well as required emergency response drill mock codes.

- Nursing leadership should develop, implement, and monitor strategies to ensure nursing staff inspect, inventory, and accurately complete documentation of logs for all EMRBs, treatment carts, and disaster response bags, in accordance with CCHCS policy.

Health Information Management (HIM)

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

HIM: Case Review Ratings and Results Summary

In this cycle, and similar to Cycle 7, case review found LAC managed health information satisfactorily. LAC staff almost always retrieved and scanned hospital discharge as well as urgent and emergent reports timely. They also generally scanned reports and records into EHRS within required timeframes. However, staff needed improvement with managing diagnostic results and specialty reports. After considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 12. Case Review Health Information Management Results

Events*	Deficiencies†	Significant Deficiencies‡
1,046	51	7

* The OIG reviewed 1,046 events.

† Deficiencies occurred in cases 1–3, 6, 7, 9, 10, 12–14, 16, 17, 19–26, and 59. Of these 51 deficiencies, 35 related to incomplete or lack of patient notification letters, eight related to untimely or lack of document scanning, two related to misfiled or mislabeled documents, one related to failure to send a record to the provider for endorsement, one related to lack of result endorsement by the provider, and four related to poor legibility.

‡ Significant deficiencies occurred in cases 13, 20, 25, and 26.

Performed Well

OIG clinicians found LAC performed well in the following:

- Hospital Reports[35]
- Urgent and Emergent Records[36]

Performed Satisfactorily, with Opportunities for Improvement

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

- Scanning Performance[37]

  LAC staff generally scanned, labeled, and filed records properly and timely. We identified 10 deficiencies, four of which were significant.[38] All significant deficiencies related to specialty services and below is one example:

  - In case 20, staff retrieved and scanned the end-of-radiation treatment summary into EHRS 19 days after the last treatment encounter.

Performed Poorly, Improvement Needed

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

- Diagnostic Reports[39]

  LAC staff needed improvement in managing diagnostic reports. We identified 36 deficiencies, 30 of which related to incomplete patient notification letters. Of the remaining six deficiencies, four related to missing patient notification letters, one related to late scanning, and one related to a provider untimely endorsing a diagnostic result. The following are examples:

  - In case 12, the provider reviewed the test result; however, the provider did not create a patient test result notification letter.

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[35] A minor deficiency in hospital report management occurred in case 22.

[36] A minor deficiency in urgent or emergent record management occurred in case 6.

[37] Minor deficiencies in scanning management occurred in cases 6, 10, 21, and 22. Significant deficiencies occurred in cases 13, 20, and 26.

[38] Six minor deficiencies in scanning management occurred in cases 6, 10, 21, and 22. Four significant deficiencies occurred in cases 13, 20, and 26.

[39] Minor deficiencies in diagnostic report management occurred in cases 1–3, 6, 7, 9, 10, 12–14, 16, 19–26, and 59. A significant deficiency occurred in case 13.

- In case 14, the provider reviewed the test result showing an elevated glucose level; however, on the patient result notification letter, the provider did not indicate the clinical significance or meaning of the lab results, such as whether the results were unchanged or within normal limits, or as expected, or whether additional testing was required.

- Specialty Reports

  Staff generally retrieved and scanned specialty reports into the EHRS on time. HIM also usually forwarded the reports to the provider for review without delay. In turn, providers generally endorsed these specialty reports within the required timeframe. We identified nine deficiencies in the management of specialty reports.[40] Below are examples of significant deficiencies:

  - In case 13, LAC staff scanned the patient's after-visit summary paperwork for an ophthalmology specialty appointment into EHRS. However, LAC staff did not obtain the specialist's report.

  - In case 25, the orthopedic surgeon performed surgery on the patient's right hand. LAC staff obtained the surgeon's operative report, which was illegible. However, LAC staff did not obtain the dictated operative report.

  We also discuss health information management in the **Specialty Services** indicator.

[40] Three minor deficiencies occurred in cases 13, 21, and 26. Six significant deficiencies occurred in cases 13, 20, 25, and 26.

Clinician On-Site Inspection

We interviewed the health information management (HIM) supervisor and inspected the HIM department. The supervisor reported LAC employs four full-time and two part-time health record technicians (HRTs). Office technicians collect medical records twice each day, at 7:30 a.m. and 12:15 p.m., from the Triage and Treatment Area (TTA), specialty service office, medical clinics, and the Correctional Treatment Center (CTC). Staff then delivers the records to the HIM department, where HRTs label and scan the documents into the system. Then, the system transfers the scanned documents to the EHRS, as the HRTs did not have direct access to the electronic medical record. Subsequently, all medical documents were transferred to CCHCS headquarters in Sacramento for storage.

The HIM supervisor stated HRTs select from a list of predetermined labels when scanning medical records and complete the scanning process on the same day the records are received. HRTs are not able to create new labels within the system.

For hospital records, LAC has a designated Utilization Management (UM) nurse who monitors hospitalized patients. LAC usually has four to six hospitalized patients daily, and the UM nurse provides daily updates to providers regarding patients' status through email or messaging. The UM nurse also has access to Antelope Valley Hospital and Palmdale Regional Medical Center to obtain medical records, including imaging reports and hospital discharge summaries.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

HIM: Compliance Ratings and Results Summary

In this indicator, LAC performed very well with timely scanning specialty reports and correctly labeling documents. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***proficient.***

Compliance Testing Results

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

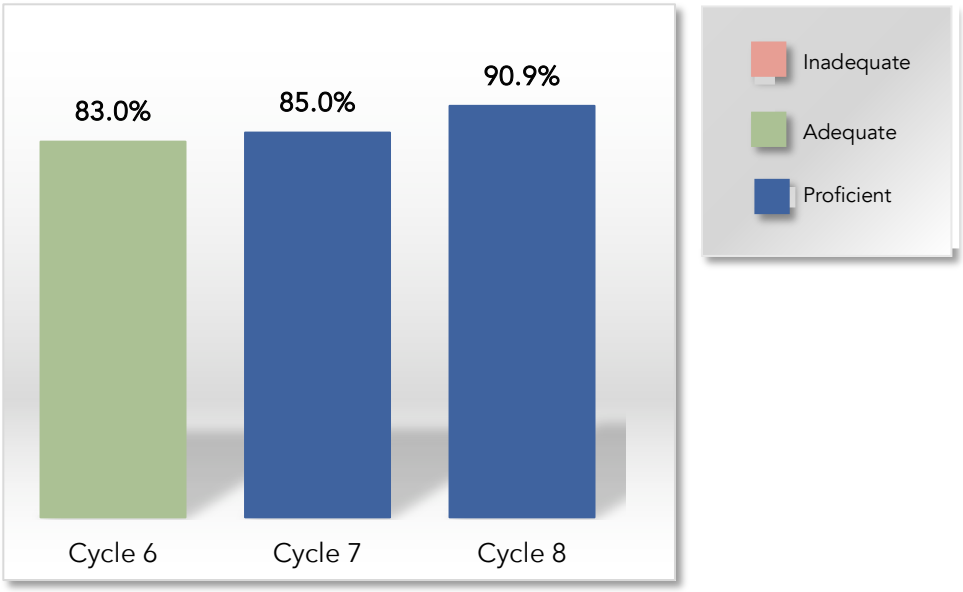
- The institution achieved a perfect compliance score for the timely integration of health care services request forms (CDCR form 7362s) into the electronic health record system (EHRS). Staff scanned all documented forms within the required timeframes, ensuring immediate data availability for the patient care team (MIT 4.001, 100%).
- The institution demonstrated exceptional operational performance ensuring community hospital discharge documents were scanned into the patients' EHRS within required timeframes for all applicable 19 sampled patients (MIT 4.003, 100%).
- The institution correctly labeled and scanned records into the patients' EHRS for 23 of 25 patients (MIT 4.004, 92.0%). For two patients, the documents were mislabeled.
- The institution exhibited proficiency ensuring the provider reviewed and endorsed community hospital discharge reports within five calendar days of discharge for 24 of 25 sampled patients (MIT 4.005, 96.0%). For one patient, the record contained no evidence the institution received the hospital discharge report.

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

- The institution ensured staff scanned specialty notes into the patients' EHRS in accordance with established timelines for 20 of 30 sampled patients (MIT 4.002, 66.7%). For 10 patients, staff scanned the specialty reports between one and 22 days late.

Analysis of Performance Across Inspection Cycles

Figure 4. Health Information Management, Compliance Scores Across Cycles



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

In Cycle 8, LAC's performance exceeded the 75.0 percent passing compliance threshold for health information management (HIM), reaching 90.9 percent in Cycle 8. This score follows the adequate performance result of 83.0 percent in Cycle 6 and the lower proficient performance result of 85.0 percent in Cycle 7. The current score represents a steady progression from previous cycles, indicating the institution's performance is continually improving and trending further above the minimum established standards for HIM.

Table 13. Health Information Management Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within one calendar day of the patient encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	20	10	15	66.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	19	0	6	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	23	2	0	92.0%
For patients discharged from a community hospital: Did a provider review and endorse the report within five calendar days of discharge? (4.005)	24	1	0	96.0%
Overall percentage (MIT 4): **90.9%**				

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 retrieve and scan all specialty reports within the required time frames.

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
PROFICIENT
Compliance Score
(86.6%)

LAC delivered a strong performance in this indicator. Based on the overall compliance score result of 86.6 percent, the OIG rated this indicator ***proficient.***

Compliance Testing Results

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

- The institution demonstrated very good performance in maintaining a clean and sanitary environment for nine of 10 clinical health care areas (MIT 5.101.2, 90.0%). In one clinic, the cabinet under the sink in the clinical area was found unclean (see Photo 7, right).

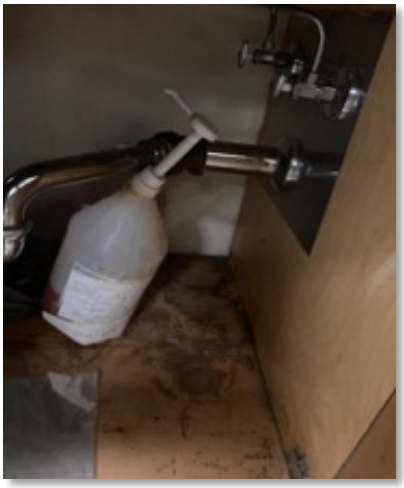


Photo 7. Cabinet found unsanitary. Photographed on 3-9-2026.

- The institution demonstrated excellent performance in ensuring staff consistently updated the corresponding cleaning logs for all 10 clinics (MIT 5.101.3, 100%).
- All 10 clinics ensured clinical health care areas contained operable sinks and sufficient quantities of hygiene supplies (MIT 5.103, 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 are conducive to providing medical services for all applicable sampled 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 remain 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 exam rooms were equipped with working computer stations, well-maintained furniture, and accessible medical equipment (MIT 5.110.3, 100%).
- Nine of 10 clinics ensured exam rooms allow for privacy and confidentiality when providing medical services (MIT 5.110.4, 90.0%). In one clinic, the examination room lacked adequate provisions for visual privacy (see Photo 8, right).

Photo 8. Exam room lacking visual privacy for the patient. Photographed on 3-10-2026

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

- The institution ensured reusable non-invasive medical equipment was properly disinfected as warranted for two of three applicable clinical health care areas (MIT 5.102.2, 66.7%). For one clinic, the health care staff failed to remove exam table paper after conducting a patient encounter.

- Only three of seven medical staff observed properly adhered to universal hand hygiene precaution, in which staff follows proper handwashing protocols (MIT 5.104, 42.9%). In four clinics, clinicians did not wash or sanitize their hands before and after physically touching the patient.

- Four of six clinics ensured adequate management and storage of bulk medical supplies (MIT 5.107, 40.0%). Specific deficiencies for six clinics included medical supplies stored in the same area with germicides, storage of supplies beyond manufacturer's guidelines (see Photo 9, right and Photo 10, below left), and improper co-storage of long-term food in the clinic area (see Photo 11, below right).

Photo 9. Expired medical supplies.
Photographed on 3-9-2026.

Photo 10. Expired medical supplies.
Photographed on 3-9-2026.

Photo 11. Improper co-storage of long-term food.
Photographed on 3-9-2026.

- Seven of 10 clinics ensured common areas and exam rooms are equipped with essential core medical equipment and supplies (MIT 5.108.2, 70.0%). In three clinics, we found one or more of the following deficiencies: staff did not consistently conduct daily performance checks of the automated external defibrillator (AED); the examination table was missing disposable paper; the specialty clinic oto-ophthalmoscope was non-functional; and a glucometer quality control log was incomplete.

The following tests 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 LAC 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.

- The facility demonstrated excellent equipment oversight, maintaining an uninterrupted inventory of clinical supplies and ensuring essential equipment remained in proper working order. While a motorized ophthalmic table supporting the Optical Coherence Tomography (OCT) device was briefly identified as malfunctioning (MIT 5.108.1, N/A), medical leadership took immediate, commendable action to resolve the issue while the inspection team was onsite.

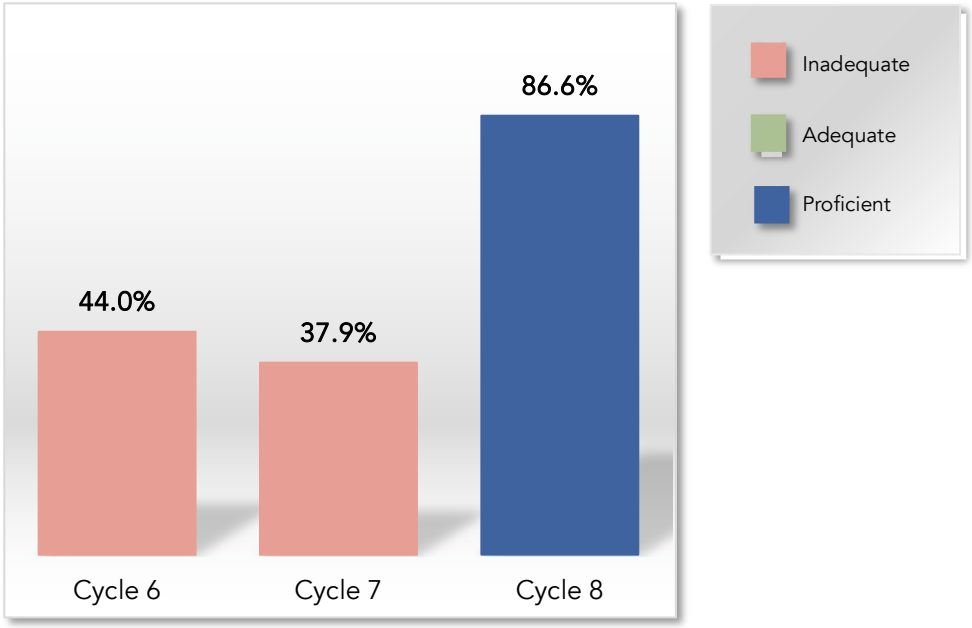
- We inspected indoor patient waiting areas. Health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 12, right). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas (MIT 5.109.2, N/A).

Photo 12. Sufficient patient waiting area. Photographed on 3-10-2026.

- We also note the compliance test for MIT 5.102.1 in this indicator was not applicable during the inspection cycle as no sterilization or chemical cleaning procedures are conducted at this institution (MIT 5.102.1, N/A).

Analysis of Performance Across Inspection Cycles

Figure 5. Health Care Environment, Compliance Scores Across Cycles



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

In Cycle 8, LAC performed well above established standards for health care environment, successfully exceeding the requirements for this cycle. The institution surpassed the 75.0 percent passing compliance threshold for health care environment, reaching 86.6 percent in Cycle 8. This rating demonstrates significant improvement following previous inadequate ratings of 44.0 percent in Cycle 6 and 37.9 percent in Cycle 7, to a proficient performance in this cycle, indicating a highly successful commitment to progress in this area.

Table 14. Health Care Environment Compliance Test Scores

	Scored Answer			
Compliance Questions	**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)	9	1	0	90.0%
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)	10	0	0	100%
Infection control: Do clinical health care areas ensure that reusable invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.1)	0	0	10	N/A
Infection control: Do clinical health care areas ensure that reusable non-invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.2)	2	1	7	66.7%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	10	0	0	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	4	3	42.9%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	0	100%
Warehouse, Conex, and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	4	6	0	40.0%
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)	7	3	0	70.0%
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)	9	1	0	90.0%
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): **86.6%**

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 for staff not following all required universal hand hygiene precautions 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 Rating and Results Summary

In this cycle, case review found LAC performed sufficiently in the transfer process. OIG clinicians found LAC nurses frequently performed thorough assessments and scheduled provider follow-up appointments as required when patients arrived at LAC. During the transfer-out process, nurses almost always ensured all requirements were met. For hospital returns, nurses mostly performed thorough patient assessments and frequently provided continuity of medications. However, OIG clinicians found opportunities for improvement with medication management and nursing assessments. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 15. Case Review Transfers Results

Transfer Events*	Deficiencies†	Significant Deficiencies‡
39	12	4

* The OIG clinicians reviewed 39 events in 18 cases in which patients transferred into or out of the institution and 17 events in which patients returned from an off-site hospital or emergency room.

† Deficiencies occurred in cases 1, 8, 22, 29, 31, 32, and 60.

‡ Significant deficiencies occurred in cases 1, 8, and 31.

Performed Well

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

Performed Satisfactorily with Opportunities for Improvement

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

- Transfers In[41]

  OIG clinicians found LAC nurses performed thorough initial healthcare screenings, requested provider appointments within the required time frames, and provided patient education. The nurses ensured patients had their durable medical equipment and communicated with the providers to renew medications and pending appointments. Transfer-in provider appointments occurred timely. Medication management was generally satisfactory; however, we identified one significant medication management deficiency. Please refer to the **Medication Management** indicator for further details.

- Transfers Out[42]

  OIG clinicians found LAC nurses screened patients as required. The nurses almost always communicated pending specialty appointments and missing patient medications. They ensured medications were not expiring within five days and patients had their durable medical equipment prior to transferring out of LAC. Nurses almost always

[41] OIG clinicians reviewed eight transfer-in events in cases 8 and 28–30. Transfer-in deficiencies occurred in cases 8 and 29. A significant deficiency occurred in case 8.

[42] OIG clinicians reviewed seven transfer-out events in cases 3 and 31–33. Transfer-out deficiencies occurred in cases 31 and 32. Two significant deficiencies occurred in case 31.

provided medications timely. Please refer to the **Medication Management indicator** for further details. The following is a nursing performance significant deficiency:

- In case 31, the diabetic patient transferred out of LAC to another institution. The RN checked the patient's fingerstick blood sugar (FSBS) result, and the monitor showed a "high" reading. The nurse did not repeat the "high" FSBS reading or assess the patient for signs and symptoms of high blood sugar; did not notify the PCP regarding the abnormal reading for further plan of care prior to transfer; did not document communicating to the receiving facility regarding the pending referral for a routine orthopedic surgery evaluation; and did not document the patient's respiratory rate.

- Hospital Returns[43]

  OIG clinicians found nurses mostly performed appropriate assessments, reviewed the hospital discharge documents, and communicated with the providers. Hospital return provider follow up appointments occurred timely, and LAC staff scanned hospital documents within the required timeframe. LAC frequently maintained medication continuity when patients returned from a hospitalization. The following example is a significant deficiency:

  - In case 1, the patient returned from a community emergency room for abscess to the right upper arm. The triage and treatment (TTA) RN assessed the patient and documented vital signs were within normal limits, temperature was stable, and pulse was regular but did not document the numeric values of these vital signs. However, the nurse also documented the patient refused vital signs, despite including the above partial assessment of vital signs. Additionally, the nurse did not contact the provider regarding wound packing, which needed to be removed in two days after returning from the ER, and possible dressing changes.

Performed Poorly, Improvement Needed

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

[43] OIG clinicians reviewed 17 hospital return events in cases 1-3, 21-23, and 60. Hospital return deficiencies occurred in cases 1 and 60. A significant deficiency occurred in case 1.

Clinician On-Site Inspection

During the onsite inspection, the OIG clinician inspected LAC's receiving and release (R&R) area. The RN interviewed reported an RN is staffed on each shift. The RN indicated the R&R nurses prepared patients housed in the yards for departure and assessed newly arrived patients. In addition, the nurses assessed patients transferring to and returning from jails for court appearances. The RN indicated the correctional treatment center (CTC) nurse performs the transfer tasks when patients are housed in the CTC. The RN reported, one week prior to transfer, custody staff shared a list of patients scheduled to transfer. Although the RN indicated the nurses start preparing for the transfer immediately, the patient care summary form is not printed and placed into the envelope until around two days prior to transfer to ensure the information is thorough and accurate.

Case Review Recommendations

The OIG offers no recommendations for this indicator.

Transfers: Compliance Ratings and Results Summary

LAC demonstrated very good performance for this indicator. Based on the overall compliance score result of 88.5 percent, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Testing Results

LAC 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 timeframe for all 25 sampled patients (MIT 6.001, 100%).
- Nursing staff showed proficiency in completing the assessment and disposition sections of the initial health screening form for 24 of 25 sampled patients (MIT 6.002, 96.0%). For one patient, the registered nurse (RN) did not thoroughly complete the assessment and disposition of the initial health screening form.

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

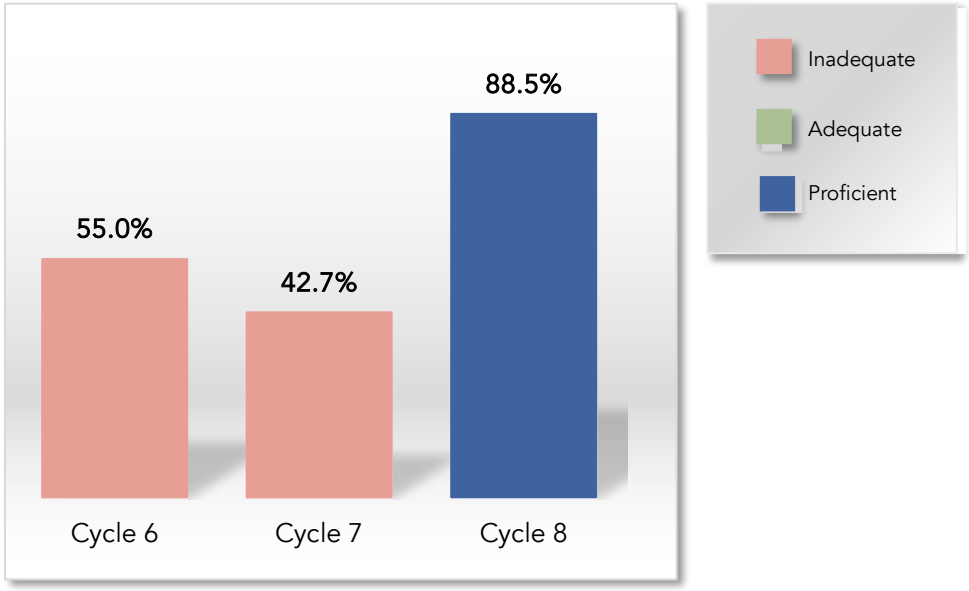
- Nursing staff ensured medications were administered or delivered without interruption for only 11 of 19 applicable sampled patients (MIT 6.003, 57.9%). For eight patients, we found one or more of the following deficiencies: incomplete documentation of the patient's stated reason for refusing medication and incomplete documentation of the patient's stated reason for not presenting to the medication line.

Compliance On-site Inspection and Discussion

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

Analysis of Performance Across Inspection Cycles

Figure 6. Transfers, Compliance Scores Across Cycles



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

In Cycle 8, LAC performed above established standards for Transfers, successfully exceeding the requirements for this cycle. The institution surpassed the 75.0 percent passing compliance threshold for this indicator, reaching 88.5 percent in Cycle 8. Although LAC's performance regressed from 55.0 percent in Cycle 6 to 42.7 percent in Cycle 7, the institution achieved a remarkable improvement, now performing in the proficient range in Cycle 8. This significant surge 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)	25	0	0	100%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	24	1	0	96.0%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or issued without interruption? (6.003)	11	8	6	57.9%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	4	0	0	100%
Overall percentage (MIT 6): **88.5%**				

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 LAC's overall performance in medication management was very good. Our clinicians found the institution performed exceptionally in medication continuity for patients returning from the hospital and patients in specialized medical housing. However, we found opportunities for improvement in ensuring patients received their newly prescribed medications without interruption as well as ensuring medication continuity for patients on chronic care medications and patients who transfer in or out of the institution. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 17. Case Review Medication Management results

Medication Events*	Deficiencies†	Significant Deficiencies‡
163	23	13

* The OIG clinicians reviewed 163 events in 34 cases related to medications.

† Deficiencies occurred in cases 1, 6, 7, 8, 11, 13, 14, 16, 17, 19, 22, 23, 26, 31, and 32.

‡ Significant deficiencies occurred in cases 1, 6, 7, 8, 11, 13, 16, 19, 22, 26, and 31.

Performed Well

OIG clinicians found LAC performed well in the following:

- Hospital Discharge Medications[44]
- Specialized Medical Housing Medications[45]

Performed Satisfactorily with Opportunities for Improvement

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

- Chronic Medication Continuity[46]

  OIG clinicians found most patients with chronic care conditions received their medications timely. However, the following are examples of lapses in medication management:

  - In case 17, during August 2025, the patient did not receive their chronic care, anti-seizure, keep-on-person (KOP) medication and nasal spray.[47] The medication administration record (MAR) documentation erroneously stated, "Not Done: No Show/No Barriers" and "Not done: Task Duplication." As a result, the patient did not receive the medications until September 2025.

  - In case 19, during August 2025, the patient, who had a history of high blood pressure and high cholesterol, did not receive three different blood pressure medications. We found no documentation in the MAR for the reason the patient did not receive the medications. In addition, the patient was prescribed nitroglycerin to self-administer for chest pain.[48] During the months of August, October, November, and December 2025, the patient requested and received at least three KOP refills in each of these months. Despite this unusually frequent use, we found no documentation from the care team or pharmacy staff acknowledging the multiple refills and increase in usage. The care team did not assess the patient for chest pain or frequent nitroglycerin use and did not provide patient education.

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[44] A hospital discharge medication deficiency occurred in case 22. No significant deficiencies occurred.

[45] A specialized medical housing medication deficiency occurred in case 1. No significant deficiencies occurred.

[46] Chronic care medication deficiencies occurred in cases 6, 11, 14, 17, 19, 23 and 26. Significant deficiencies occurred in cases 6, 11, 19, and 26.

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

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

- In case 26, in August and September 2025, the patient was scheduled to receive his chronic care, anti-seizure, KOP medication. Nursing staff documented "Not Done: No Show/No Barriers" and documented "Was not nurse on duty, clearing task." As a result, the patient did not receive his anti-seizure medication for two months.

- Newly Prescribed Medication[49]

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

  - In case 13, the patient underwent a planned vitrectomy procedure with an ophthalmologist.[50] The ophthalmologist recommended the patient receive the post-surgical prescription antibiotic, with steroid eye drop medication, every four hours while awake. However, the patient received the prescribed KOP eye medication 10 days late.

  - In case 16, the provider ordered a new KOP blood pressure medication, lisinopril, to start in November 2025. However, the patient received the medication one month later.

- Transfer Medications[51]

  Our clinicians found LAC nurses generally ensured patients received their medications when patients transferred in or out of the institution. However, we identified some deficiencies. The following are significant deficiencies:

  - In case 8, the patient with a history of ulcerative colitis arrived to LAC.[52] On the day of arrival, the Central Fill pharmacy sent an electronic message to the LAC pharmacy and the receiving and release (R&R) message pool indicating the patient's Humira injection was not administered the day before. The message requested LAC to administer the dose ASAP.[53] However, the patient did not receive the medication until six days later. In addition, nursing staff documented the patient arrived with KOP medications, aspirin, and medication to treat cholesterol but also documented the patient did not take his KOP medication to the housing unit. The patient did not receive these medications until the following month to self-administer.

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[49] Newly prescribed medication deficiencies occurred in cases 1, 7, 13, 16, and 22. All deficiencies were significant.

[50] A vitrectomy is a specialized eye surgery to treat problems with the retina.

[51] Transfer medication deficiencies occurred in cases 8, 31, and 32. Significant deficiencies occurred in cases 8 and 31.

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

[53] Humira is a prescription biologic medication used to treat various autoimmune and inflammatory conditions such as ulcerative colitis.

- In case 31, the patient was scheduled to receive five units of insulin in the morning, prior to transfer to another institution. However, on the day the transfer, the nurse administered 10 units of regular insulin, which resulted in the patient receiving double the dose of insulin he should have received.

Performed Poorly, Improvement Needed

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

Clinician On-Site Inspection

The OIG clinicians inspected the medication distribution areas (MDR) and learned, in facilities A, B, and C, patients presented to the corresponding MDRs to receive their prescribed medications. However, in facility D, psychiatric technicians administered medications within the housing units. In facilities A, B, and C, the nurses informed the housing units when patients had KOP medications for pick up. The nurses indicated they sometimes placed a list of patients with medications for pick up on the MDR window. The nurses stated, despite the notifications, patients often did not pick up their prescribed medications; subsequently, after 96 hours or four days, the medications are returned to the pharmacy.

The OIG clinicians met with the pharmacist-in-charge (PIC) and chief nurse executive (CNE) and discussed specific cases. The PIC shared he instructed the pharmacy staff to notify providers when their patients requested rescue medications more than once monthly. However, the pharmacist was not required to always document when they communicated with providers regarding prescriptions.

The clinicians also learned, when patients transferred from LAC to other institutions, the pharmacy staff usually provided patients with a five-day supply of any patient-specific medication not included in the standardized LCC list.[54]

Case Review Recommendations

- Medical and nursing leadership should determine the root cause of challenges related to medication continuity for chronic care medications and newly prescribed medications and should implement and monitor remedial measures as appropriate.

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

Medication Management: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(73.9%)

LAC's performance showed opportunities for improvement in this indicator. Based on the overall compliance score result of 73.9 percent, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

LAC 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 timeframes for 17 of 18 applicable sampled patients (MIT 7.002.1, 94.4%). For one patient, the pharmacy did not make newly ordered medications available to the patient within the required timeframe.

- The institution administered or issued new order prescription medications within required timeframes for 20 of 23 applicable sampled patients (MIT 7.002.2, 87.0%). In three patients, we found one or more of the following deficiencies: incomplete documentation of the patient's stated reason for refusing medication or reason for not presenting to the medication line, or the record contained no evidence the medication was issued to the patient timely.

- The provider ordered post-hospitalization medication orders within the required timeframes for 23 of 24 applicable sampled patients (MIT 7.003.1, 95.8%). For one patient, the medications were not ordered timely within eight hours of the patient's return from the hospital.

- The institution adequately stored and secured narcotic medications in eight of nine applicable clinic and medication line locations (MIT 7.101, 88.9%). For one location, the narcotic medication (Ativan) stored in the medication refrigerator did not remain under double lock control when not in active use, as required by policy.

- Staff successfully stored valid, unexpired medications in all nine applicable medication line locations (MIT 7.104, 100%).

- 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%).

- LAC pharmacy followed general security, organization, and cleanliness management protocols in its main pharmacy (MIT 7.108, 100%).

- LAC properly stored nonrefrigerated medication in the pharmacy location (MIT 7.109, 100%).

- The institution properly stored refrigerated or frozen medications in its main pharmacy (MIT 7.110, 100%).

- The pharmacist-in-charge (PIC) properly accounted for narcotic medications stored in the main pharmacy (MIT 7.111, 100%).

- We examined 22 medication error reports. The PIC timely and correctly processed all reports (MIT 7.112, 100%).

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

- Nurses exercised proper hand hygiene and contamination control protocols in five of six applicable locations (MIT 7.105, 83.3%). In one location, some nurses neglected to wash or sanitize hands when required. These occurrences included before preparing and administering medications, or before each subsequent re-gloving.

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

- Only six of 17 applicable patient samples received chronic care medications within required timeframes (MIT 7.001, 35.3%). In 11 patients, we found one or more of the following deficiencies: chronic care medications were not timely made available to the patients; the record contained no evidence the patient either refused or received their chronic care medications; and "keep on person" (KOP) medications were not issued within policy timeframes.

- The institution's pharmacy made available post-hospitalization medication orders within the required timeframe for only eight of 20 applicable sampled patients (MIT 7.003.2, 40.0%). In 12 patients, the pharmacy was not timely in filling and dispensing medications as ordered.

- The institution administered or issued post-hospitalization medication orders within the required timeframes for eight of 24 applicable sampled patients (MIT 7.003.3, 33.3%). In 16 patients, we found one or more of the following deficiencies: incomplete documentation of the patient's stated 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 timeframes.

- The institution administered or delivered medications without interruption for patients transferring within the institution for 17 of 25 patients (MIT 7.005, 68.0%). For eight patients, nursing staff failed to completely document the patient's stated reasons why they did not present to the medication line.

Photo 13. Nurses did not maintain unissued medication in original labeled packing. Photographed on 3-9-2026.

- The institution administered or delivered medications without interruption to patients laying over at LAC for four of 10 sampled patients (MIT 7.006, 40.0%). For six patients, we found one or more of the following deficiencies: incomplete documentation of the patient's stated reason for refusing medication or reason for not presenting to the medication line; and KOP medications were not issued within policy timeframes.

- LAC appropriately stored and secured non-narcotic medications in five of nine applicable clinic and medication line locations (MIT 7.102, 55.6%). In four locations, nurses did not maintain unissued medication in its original labeled packing (see Photo 13, left).

- Staff kept medications protected from physical, chemical, and temperature contamination in only two of nine applicable clinic and medication line locations (MIT 7.103, 22.2%). In seven locations, we found one or more of the following deficiencies: medication refrigerators were unsanitary (see Photo 14, right), and staff did not store oral and topical medications separately.

Photo 14. Medication refrigerator found unsanitary.
Photographed on 3-9-2026.

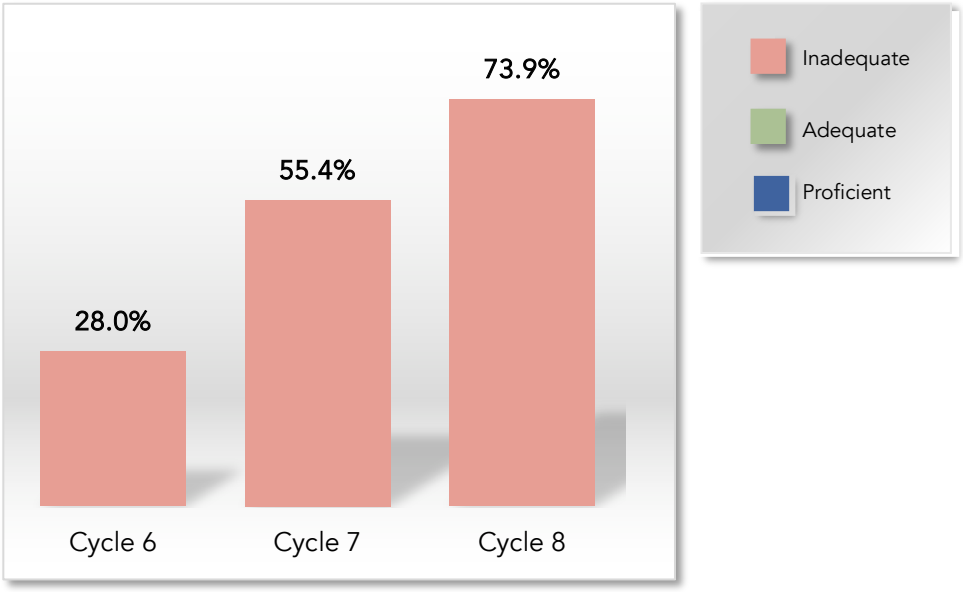
- Staff in only two of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 33.3%). In four locations, we found one or more of the following deficiencies: medication nurses did not always ensure patients swallowed direct observed therapy (DOT) medications; and medication nurses did not follow CCHCS care guide requirements when administering Suboxone medication.

The following tests 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 LAC, 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. Fifteen of the 20 applicable patients interviewed indicated they had access to their rescue medications. Five 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).

Analysis of Performance Across Inspection Cycles

Figure 7. Medication Management, Compliance Scores Across Cycles



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

In Cycle 8, LAC performed below established standards for medication management. The institution did not meet the 75.0 percent passing compliance threshold for this indicator, attaining only 73.9 percent in Cycle 8. While this score demonstrates significant sustained progress from 28.0 percent in Cycle 6 and 55.4 percent in Cycle 7, the overall performance in this indicator still remains slightly below adequate levels, highlighting a continuing need for improvement.

Table 18. Medication Management Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	6	11	8	35.3%
Did health care staff make available, new order prescription medications to the patient within the required time frames? (7.002.1)	17	1	7	94.4%
Did health care staff administer or issued new order prescription medications to the patient within the required time frames? (7.002.2)	20	3	2	87.0%
Upon the patient's discharge from a community hospital: Did the provider order the medications within required time frames? (7.003.1)	23	1	1	95.8%
Upon the patient's discharge from a community hospital: Were all ordered medications made available to the patient within required time frames? (7.003.2)	8	12	5	40.0%
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)	8	16	1	33.3%
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)	17	8	0	68.0%
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)	4	6	0	40.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	8	1	1	88.9%
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)	5	4	1	55.6%
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)	2	7	1	22.2%
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)	9	0	1	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	5	1	4	83.3%
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)	2	4	4	33.3%
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)	1	0	0	100%

Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	22	0	0	100%
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): **73.9%**				

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 properly 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

LAC performed very well in this indicator. Based on the overall compliance score result of 91.7 percent, the OIG rated this indicator ***proficient***.

Compliance Testing Results

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

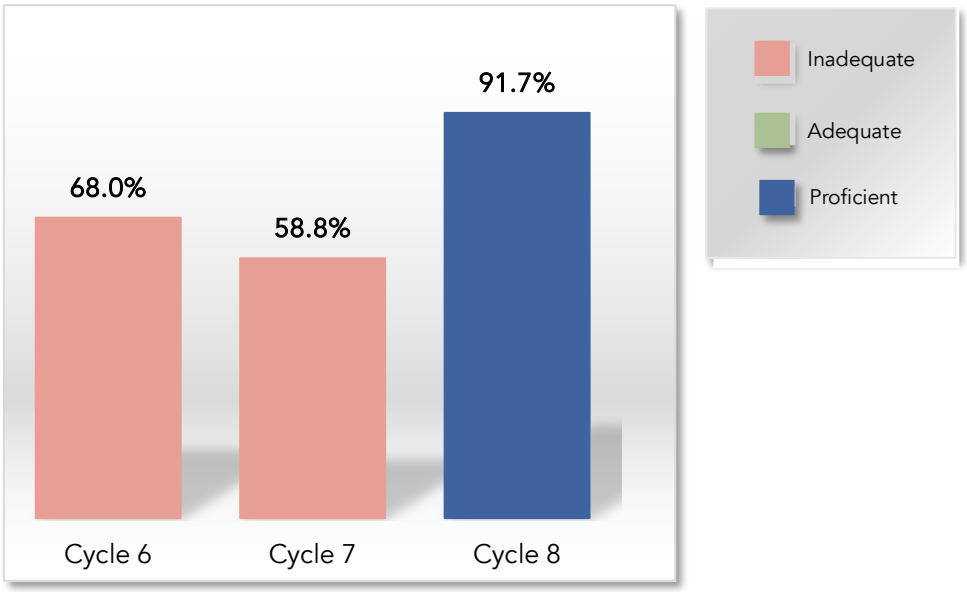
- The institution demonstrated proficiency in screening patients for tuberculosis (TB) for all 25 sampled patients (MIT 9.003, 100%).
- The institution demonstrated proficiency in offering influenza vaccinations during the most recently completed influenza season for all 25 sampled patients (MIT 9.004, 100%).
- The institution demonstrated proficiency in offering colorectal cancer screening to 23 of 25 patients (MIT 9.005, 92.0%). In two patients, the record contained no evidence indicating whether the patient was offered, completed, or refused a fecal immunochemical test (FIT) in the last 12 months.
- The institution offered immunizations to chronic care patients for all 14 sampled patients (MIT 9.008, 100%).

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

- The institution properly administered TB medications for 15 of 18 sampled patients (MIT 9.001, 83.3%). For three patients, nursing staff did not document the patient's stated reason for not presenting to the medication line.
- The institution monitored patients taking TB medications during the treatment period for 12 of 16 applicable sampled patients (MIT 9.002, 75.0%). In four patients, we found no evidence of monthly monitoring completed within policy requirements.

Analysis of Performance Across Inspection Cycles

Figure 8. Preventative Services, Compliance Scores Across Cycles



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

In Cycle 8, LAC performed above established standards for preventive services, successfully exceeding the requirements for this cycle. The institution surpassed the 75.0 percent passing compliance threshold for preventive services, reaching 91.7 percent in Cycle 8. Although LAC's performance decreased from 68.0 percent in Cycle 6 to 58.8 percent in Cycle 7, the institution achieved a remarkable improvement, now performing in the ***proficient*** range in Cycle 8, indicating the institution is now trending significantly above the established benchmarks.

Table 19. Preventive Services Compliance Test Scores

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	15	3	0	83.3%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent 90-day period they were on the medication? (9.002)	12	4	2	75.0%
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)	14	0	11	100%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **91.7%**

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

Compliance Recommendations

The OIG offers no compliance recommendations for this indicator.

Nursing Performance

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVN), psychiatric technicians (PTs), certified nursing assistants (CNAs), and medical assistants (MAs). 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. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

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

Nursing Performance: Case Review Ratings and Results Summary

LAC's overall nursing care was timely and appropriate. Compared to Cycle 7, nursing care displayed marked systemic improvements. Specifically, nurses performed good care in the transfer-in process and wound care. Nurses provided sufficient care in the following areas: outpatient, emergency services, transfer-out process, hospital returns, specialty services, and medication management. However, we found nursing performance needed improvement in the specialized medical housing. Considering all factors, the OIG clinicians rated this indicator ***adequate.***

Case Review Results

Table 20. Case Review Nursing Performance Results

Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
243	96	16

* We reviewed 243 nursing encounters in 50 cases. Of the nursing encounters we reviewed, 100 were in the outpatient setting,
† Deficiencies occurred in cases 1–3, 5–10, 17–23, 29, 31, 35, 36, 38, 46, 47, 49, 50, 55, 56, and 58–60.
‡ Significant deficiencies occurred in cases 1, 17, 19, 22, 31, and 59.

Table 21. Case Review Outpatient Nursing Performance Results

Outpatient Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
100	38	8

* Nursing outpatient nursing encounters occurred in cases 1, 2, 6–10, 17–23, and 34–57. Among the total number of nursing outpatient events, 62 were sick call events. Sick call events occurred in cases 1, 2, 7–9, 17–22, and 34–57.
† Outpatient nursing deficiencies occurred in cases 1, 2, 7–10, 17–22, 35, 36, 38, 46, 47, 49, 50, 55, and 56.
‡ Significant deficiencies occurred in cases 1, 17, and 19.

Performed Well

OIG clinicians found LAC nurses performed well in the following:

- Transfer-in[55]

  OIG clinicians found LAC nurses performed thorough initial healthcare screenings, requested provider appointments within the required time frames, and provided good patient education. Please refer to the **Transfers** indicator for further details.

- Wound care[56]

  We found RNs provided good wound care and completed corresponding documentation.

Performed Satisfactorily with Opportunities for Improvement

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

- Outpatient Nursing Assessments, Interventions, and Documentation

  LAC nurses performed acceptably in sick call triage. Nurses identified symptomatic sick calls and appropriately initiated appointments. On most occasions, nurses completed sufficient assessments and initiated appropriate interventions; however, on a few occasions, we found incomplete nursing assessments and interventions. In addition, we

[55] A transfer-in nursing performance deficiency occurred in case 29. No significant deficiencies occurred.
[56] Wound care deficiencies occurred in cases 1, 9, and 23. No significant deficiencies occurred.

found occasional occurrences when the nurses did not document thoroughly. The following are examples:

- In case 1, an LVN contacted an RN when this patient presented to the clinic with complaints of right arm pain and an inability to lift his arm for nine days. The RN did not assess the patient or perform a telephone triage. Instead, the RN informed the LVN to give the patient a sick call request.

- In case 17, an RN assessed this patient for complaints of feeling sick, weight loss, upset stomach, nausea, and diarrhea. However, the RN did not take the patient's temperature and did not perform a complete abdominal assessment. The nurse also did not listen to the patient's bowel sounds and did not document the date of the patient's last bowel movement.

- In case 19, an LVN obtained this patient's blood pressure after he indicated his heart was racing. Although the LVN obtained the patient's blood pressure result, the LVN did not obtain the patient's pulse, respiratory rate, and oxygen saturation result. Additionally, the LVN did not notify an RN or provider of the patient's complaint.

- Emergency Services

  Nursing staff responded immediately to medical alarms, assessed patients, provided appropriate interventions, adequate documentation, and consulted the provider when appropriate. Nursing leadership completed emergency clinical reviews and identified opportunities for improvement. However, nursing staff did not always perform thorough assessments and documentation. Please refer to the **Emergency Services** indicator for further details.

- Transfer-out

  LAC nurses screened patients as required. The nurses almost always communicated pending specialty appointments and missing patient medications to the receiving institution. Please refer to the **Transfers** indicator for further details.

- Hospital Returns

  LAC nurses frequently performed appropriate assessments, reviewed the hospital discharge documents, and communicated with the providers. Please refer to the **Transfers** indicator for further details.

- Specialty Services

  Nurses often performed satisfactory assessments, reviewed specialist recommendations, and contacted the providers as needed when patients returned from off-site specialty

appointments. However, our clinicians found nurses did not always perform thorough nursing assessments. Please refer to the **Specialty Services** indicator for further details.

- Medication Management

  Institutional nurses generally administered medications properly and as prescribed. Please refer to the **Medication Management** indicator for further details.

Performed Poorly, Improvement Needed

Our clinicians found LAC performed poorly in the following:

- Specialized Medical Housing

  The CTC nurses performed excellently in timely administering medications. However, OIG clinicians identified a pattern of incomplete nursing admission assessments, incomplete daily assessments, and other inconsistent or incomplete documentation. Please refer to the **Specialized Medical Housing** indicator for further details.

Clinician On-Site Inspection

The OIG clinicians inspected LAC's A, B, C, and D clinics. Each of these four clinics was staffed with two RNs and one medical provider. However, in the A clinic, one RN split time between the A medical clinic and the minimum-security facility (MSF).[57] The RNs staffed in each clinic were not assigned a specific patient panel; instead, the RNs triaged based on their availability.

The SRN we interviewed explained the medical clinic supervisors performed sick call audits to assess compliance and quality. She indicated the Quality Management department selected the patients' records to audit and included patients who previously had symptomatic RN appointments.

The OIG also met with the CNE, who had been in her position for almost three years. Prior to her work at LAC, she worked in nursing leadership at another institution. During the interview, the CNE often referenced reliance on the HCDOM and workflows to ensure guidance and directives were in line with statewide operations. She indicated educating her nursing staff and supervisors was a priority. Throughout the OIG interviews, the CNE demonstrated her ongoing commitment to improving LAC's nursing care.

[57] The minimum-security facility (MSF) is the lowest security level within a correctional system and is designated for incarcerated individuals who are considered to pose a low risk of violence, escape, or institutional misconduct.

Case Review Recommendations

The OIG offers no recommendations for this indicator.

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 LAC providers performed variably in delivering medical care. Analysis of the sub-indicators highlighted areas of both strength and concern. LAC providers performed well or satisfactorily in six of the nine sub-indicators. However, we found weak performance in outpatient assessment and decision-making, specialized medical housing care, and the completion of patient notification letters. Notably, we identified more individual deficiencies among LAC providers than in Cycle 7, but the number of *inadequate* overall performances in 25 detailed case reviews decreased from four in Cycle 7 to three in the current cycle. Specifically, 24 of the 74 deficiencies (32 percent) concentrated in the three *inadequate* cases. Thus, despite the increase of individual deficiencies, overall provider performance generally showed slight improvement. Although deficiencies remained in several areas, the reduction in *inadequate* cases and the satisfactory to good performance across multiple sub-indicators supported an overall ***adequate*** rating for provider performance.

Case Review Results

Table 22. Case Review Provider Performance Results

Provider Encounters*	Deficiencies†	Significant Deficiencies‡
110	74	29

* The OIG reviewed 110 provider encounters.

† Deficiencies occurred in cases 1, 2, 8, 10, 13–26, and 58–60.

‡ Significant deficiencies occurred in cases 1, 10, 13, 14, 17–19, 22, 23, 25, 26, 58, and 60.

Table 23. Provider Performance Detailed Cases Results

Total Detailed Cases Reviewed	Proficient	Adequate	Inadequate
25	0	22	3

Performed Well

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

- Provider Continuity[58]
- Outpatient Review of Records[59]

Performed Satisfactorily with opportunities for improvement

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

- Emergency Care

  LAC providers performed sufficiently in this sub-indicator. However, OIG clinicians identified 10 deficiencies, four of which were significant.[60] The following is an example:

  - In case 19, the patient complained of chest pain and had elevated blood pressure. Nursing staff contacted the provider for further direction. However, the provider did not document a progress note explain medical rationale for the treatment given.

  Additional details are discussed in the **Emergency Care** indicator section.

[58] The OIG identified no deficiencies in this sub-indicator.

[59] Deficiencies occurred in cases 1 and 13. A significant deficiency occurred in case 13.

[60] Deficiencies occurred in cases 1, 2, 14, 17, 19, 22, and 25. Significant deficiencies occurred in cases 14, 17, 19, and 22.

- Outpatient Documentation Quality

  The OIG clinicians reviewed 68 outpatient provider encounters and found LAC providers mostly documented medical records appropriately. However, we identified eight minor deficiencies related to missing progress notes.[61] Examples include the following:

  - In case 20, a nurse consulted a provider about the patient's left shoulder pain. Although the provider ordered an x-ray, the provider did not document a progress note.
  - In case 24, a nurse consulted a provider about the patient's right hand pain. Although the provider ordered an x-ray, the provider did not document a progress note.

- Chronic Care

  The OIG clinicians reviewed 24 chronic care encounters and identified nine deficiencies, five of which were significant.[62] We found occasional instances of providers not addressing elevated blood pressure readings; however, we found no instances of persistently uncontrolled hypertension within individual cases.

  Diabetes management was usually satisfactory, as all three detailed diabetic cases were rated ***adequate***. Nonetheless, we found opportunities for improvement, such as in the following an example:

  - In case 19, the provider adjusted the diabetic patient's insulin regimen but did not schedule close interval follow-up to reassess the sugar control.

  In contrast, OIG clinicians found providers' anticoagulation management to be poor. We rated one of the three detailed anticoagulation cases as ***inadequate***, because the care placed the patient at a significantly increased risk of harm. The following is an example:

  - In case 13, the patient with a mechanical heart valve required anticoagulation treatment with warfarin medication.[63] The patient experienced five consecutive

[61] Deficiencies occurred in cases 1, 19–21, and 23–25.

[62] Deficiencies occurred in cases 13, 16, 18, and 19.

[63] A mechanical heart valve is made of non-tissue material such as carbon and metal. This valve has a higher risk for stroke due to blood clots developing on the valve. Anticoagulation treatment with lifelong blood-thinning is required to reduce the chances of clot formation. Warfarin is a blood-thinning medication.

subtherapeutic INR levels over a 40-day period,[64] placing the patient at significant risk for thromboembolism and embolic stroke.[65]

- Specialty Services

  LAC providers performed satisfactorily in this sub-indicator. OIG clinicians identified seven deficiencies, three of which were significant.[66] We discuss additional details in the **Specialty Services** indicator.

Performed Poorly, Improvement Needed

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

- Outpatient Assessment and Decision Making

  LAC providers performed poorly in outpatient assessment or decision making as OIG clinicians identified 27 deficiencies, 11 of which were significant.[67] The following are examples:

  - In case 13, the provider reviewed the laboratory test result showing a low hemoglobin level. However, the provider did not perform further work up to determine the underlying cause.
  - In case 14, the patient sustained a head injury approximately one month prior and subsequently developed headaches and dizziness. The provider should have ordered an urgent priority brain MRI rather than a routine priority one.
  - In case 25, the provider evaluated a patient for right thumb pain but did not examine the thumb or hand for neurological, musculoskeletal, or vascular abnormalities.

[64] 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.

[65] Thromboembolism is a medical condition in which a blood clot breaks off from its original site of formation and moves through the blood vessels, eventually causing obstruction and organ damage. An embolic stroke results from a blood clot traveling through the blood vessel and blocking an artery in the brain, causing loss of blood flow and brain damage.

[66] Deficiencies occurred in cases 10, 15, 22, and 25. Significant deficiencies occurred in cases 10, 22, and 25.

[67] Deficiencies occurred in cases 1, 8, 13, 14, 17, 19, 21, 22–26, and 60. Significant deficiencies occurred in cases 1, 13, 14, 19, 25, and 26.

- Patient Notification Letters

  LAC providers needed improvement in communicating diagnostic test results to patients through notification letters. OIG clinicians identified 34 deficiencies related to missing or incomplete notification letters. The following are examples:

  - In case 16, the provider reviewed the test result showing an abnormal hemoglobin A1c level; however, on the patient result notification letter, the provider did not indicate the clinical significance or meaning of the lab results such as whether the results were unchanged or within normal limits, were as expected, or whether additional testing is required.[68]

  - In case 24, the provider reviewed the patient's MRI result showing a hand fracture; however, provider did not generate a patient results notification letter.

  We discuss in detail in the Diagnostic Services and Health Information Management indicators.

- Specialized Medical Housing

  LAC providers performed poorly in care of specialized medical housing patients. OIG clinicians identified 12 deficiencies, five of which were significant.[69] The following is an example:

  - In case 22, the provider admitted the patient to CTC after the hospitalization for severe anemia. The provider did not review the hospital records thoroughly to identify the patient had a positive test for Helicobacter pylori and to consider treatment.[70]

  Please see the **Specialized Medical Housing** indicator for further details.

[68] Hemoglobin A1c (HbA1c) is a blood test that measures the average plasma glucose over the previous 12 weeks.

[69] Deficiencies occurred in cases 1, 22, 23, and 58–60. Significant deficiencies occurred in cases 1, 22, 23, 58, and 60.

[70] Helicobacter pylori bacteria can cause infection in the stomach resulting in ulcers and inflammation. It is a risk factor for stomach cancer.

Clinician On-Site Inspection

The OIG met with LAC medical leadership and providers. The Chief Medical Executive (CME) at LAC has served the institution for more than five years, while the Chief Physician and Surgeon (CP&S) has also served the institution for approximately five years. During the inspection, the CME expressed appreciation for the providers' continued commitment to delivering quality patient care and reported no performance concerns regarding the medical staff. In addition, the CP&S supervises the two nurse practitioners and is available to assist providers with clinic coverage when needed.

Leadership reported LAC currently employs nine full-time providers as well as two and a half registry providers; two provider positions are currently vacant. To maintain continuity of care and ensure adequate cross coverage, each of the four primary clinics, Clinics A, B, C, and D, is staffed with two providers. Providers are generally responsible for two to three overnight on-call shifts per month, with additional support provided by telemedicine providers from CCHCS headquarters.

Overall, providers expressed satisfaction with the ancillary services, including specialty care, diagnostic services, and pharmacy support. Providers also reported feeling supported by LAC leadership in obtaining the resources necessary to deliver effective patient care. Examples include the pain management committee, population health management meetings, and opportunities for continuing medical education.

During the two-day inspection, the OIG physician attended two daily provider morning meetings. During these meetings, on-call providers reviewed patients returning from specialty appointments or hospitalizations, as well as significant TTA events. Following the morning reports, the OIG physician also observed clinic huddles in Clinics A and D. These interdisciplinary huddles included providers, nursing supervisors, nurses, psychologists, medical assistants, office technicians, and medication nurses. Patient team members discussed specialty consultation recommendations, reviewed patients' glucose logs, addressed hospital returns, and monitored medication refusals. Nurses additionally informed providers about scheduled clinic appointments, expiring medications, and newly arrived individuals from other institutions. Clinic A staff, in particular, reported receiving approximately five new arrivals per day, requiring coordination among staff to ensure timely provider assessment and continuity of care.

On the second day of the inspection, the OIG physician attended a Population Health Management (PHM) meeting for Clinic D. Each of the main clinic staff members conducts two PHM meetings per month. The interdisciplinary team, consisting of providers, the CME, CP&S, psychologists, psychiatrists, and nursing staff, reviewed the CCHCS Dashboard to identify patients with poorly controlled diabetes and develop strategies to improve glycemic outcomes. The team also identified patients in need of preventive health services, including colon cancer

and lung cancer screenings. In addition, providers reviewed patients with advanced liver disease who required surveillance for liver cancer and esophageal varices.[71]

Leadership reported Clinic D has a large population of patients with psychiatric disorders, as well as a high number of refusals for medical appointments and medications. The CME acknowledged that refusal of medical care is a complex issue requiring multifaceted interventions, including psychiatric evaluations and ongoing patient education regarding the risks associated with refusing treatment. To further address these concerns, the CME reported participation in forums held within each main clinic for patients to discuss their concerns privately or in group settings to better understand the reasons behind treatment refusals. Despite the challenges associated with these cases, the CME expressed optimism and emphasized the institution's commitment to patient engagement and persistent efforts to achieve positive outcomes.

Case Review Recommendations

- Medical leadership should develop, implement, and monitor strategies, such as more frequent training, 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 in managing chronic medical conditions, including anticoagulation with warfarin as well as diabetes management.

[71] Esophageal varices are dilated veins in the swallowing tube that connects the mouth to the stomach. The dilated veins occur from advanced liver disease.

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, LAC specialized medical housing consisted of a correctional treatment center (CTC).

Specialized Medical Housing: Case Review Ratings and Results Summary

In case review, LAC's medical care was mixed for specialized medical housing. The CTC nurses performed excellently on timely administering medications. However, OIG clinicians identified a pattern of nurses not thoroughly completing admission assessments, completing daily assessments, and completing thorough documentation. Additionally, OIG clinicians identified patterns of questionable decision-making and inaccurate or incomplete documentation in provider performance. Considering all factors, the OIG rated the case review component of this indicator ***inadequate.***

Case Review Results

Table 24. Case Review Specialized Medical Housing Results

CTC / OHU Events*	Deficiencies†	Significant Deficiencies‡
103	40	9

* We reviewed seven CTC cases that included 39 provider encounters and 37 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 1, 21–23, and 58–60.

‡ Significant deficiencies occurred in cases 1, 22, 23, 58, and 60.

Performed Well

OIG clinicians found LAC performed well in the following:

- Medication Management[72]

  Patients in the CTC almost always received medications without lapse in medication continuity. Please refer to the **Medication Management** indicator for further information.

Performed Satisfactorily with Opportunities for Improvement

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

Performed Poorly, Improvement Needed

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

- Provider Performance

  Providers usually evaluated the patients in CTC timely. However, OIG clinicians identified 12 deficiencies, five of which were significant.[73] OIG clinicians identified patterns of questionable decision-making and inaccurate or incomplete documentation. The following are examples:

  - In case 58, the provider evaluated the patient for left hip pain; however, the provider requested a right hip x-ray instead.
  - In case 60, the provider documented the patient with HIV should continue an antibiotic, Bactrim DS, for a left shoulder infection that required a "wound vac" (vacuum-assisted closure).[74] However, the provider did not re-order the medication to continue.

[72] A medication deficiency occurred in case 1. No significant deficiencies occurred.

[73] Deficiencies occurred in cases 1, 22, 23, and 58–60. Significant deficiencies occurred in cases 1, 22, 23, 58, and 60.

[74] A "wound vac," also known as vacuum-assisted closure of a wound, is a therapy that decreases air pressure around a wound by using continuous or intermittent suction, allowing the wound to heal more quickly.

- Nursing Performance[75]

  OIG clinicians found a pattern with CTC nurses not completing thorough admission assessments, thorough daily assessments, and documentation. The following are examples:

  - In case 1, the patient was admitted to the CTC for intravenous (IV) antibiotics after returning from the hospital for sepsis.[76] The nurse assessed the patient; however, the nurse did not weigh the patient, listen to lung and bowel sounds, or inquire about the patient's last bowel movement. Additionally, the nurse did not initiate a plan of care for neurological and respiratory status for this patient with a history of altered level of conscious and elevated ammonia levels.[77]

  - In case 22, the patient with lung cancer was admitted to the CTC from the hospital for a pleural effusion and shortness of breath, and the patient arrived with a PleurX catheter drainage system.[78] The nurse completed the admission assessment; however, the nurse did not assess and did not document the patient had a PleurX drainage device present upon admission. Additionally, the nurse did not obtain the patient's weight, listen to lung and bowel sounds, or obtain a temperature. During the admission, the patient's heart rate was elevated, but the nurse did not reassess the patient's heart rate until eight hours later. Additionally, during October 2025, the CTC nurses did not always assess the PleurX insertion site, listen to lung and bowel sounds, reassess the elevated heart rate, or notify the provider of the abnormal heart rate.

  - In case 23, the CTC RN performed an admission assessment on the patient, who returned from a hospitalization for right knee cellulitis following incision and drainage.[79] However, the nurse did not perform a thorough assessment. The nurse did not assess the patient's lung sounds or heart rhythm, describe the right knee incision measurements, or measure the midline external catheter length and arm circumference to the left upper arm.[80]

  - In case 59, the patient, who had a history of below the knee amputation, was admitted into the CTC. The patient used assisted devices, such as a walker, and

[75] Nursing performance deficiencies occurred in cases 1, 21–23, 59, and 60. Significant deficiencies occurred in cases 1, 22, 23, 58, and 60.

[76] Sepsis is a life-threatening reaction to an infection that causes the immune system to harm healthy tissues and organs.

[77] Elevated ammonia levels are a dangerous buildup of ammonia, a natural byproduct from a body digesting protein, in the patient's system. High levels of ammonia can become toxic to the central nervous system; may affect the brain, organs, and muscles; and can quickly become a medical emergency.

[78] Pleural effusion is the buildup of excess fluid in the space between the lungs and the chest wall. A PleurX catheter is an indwelling tube placed in the chest or abdomen to drain recurrent fluid buildup.

[79] An incision and drainage (I&D) is a minor procedure used to treat abscesses.

[80] A midline catheter is a long, flexible IV tube inserted into a vein in the upper arm for longer medical treatments.

prosthetic devices. However, the nurse incorrectly indicated the patient did not utilize an ambulatory aid, which resulted in the nurse incorrectly listing the fall risk score as a "low" risk for falls.

Clinician On-Site Inspection

The clinician inspected the CTC. The CTC had 16 beds, four of which were reserved for patients admitted for "medical" reasons, two of which were negative pressure rooms. The remaining 12 beds were reserved for mental health patients. The nurses we interviewed indicated three RNs were staffed each shift and cared for both medical and mental health patients. The RNs provided assessments and administered their patients' medications. They indicated upon admission, their patient care plans were developed with the assigned provider. The CTC nurses and nursing leadership indicated most of the medical patients' admissions were for intravenous antibiotics via a PICC line.[81] Subsequently, to evaluate and ensure proper nursing care, the CNE had initiated a PICC line nursing audit.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure CTC nurses thoroughly complete initial and daily patient assessments as well as complete documentation. Leadership should implement and monitor remedial measures as appropriate.

- Medical leadership should develop strategies to ensure CTC providers thoroughly review and update documentation to ensure medication continuity and implementation of the hospital discharge recommendations to ensure continuity of care. Leadership should implement and monitor remedial measures as appropriate.

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

Specialized Medical Housing: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(57.1 %)

LAC needs significant improvement in this indicator. Based on the overall compliance score result of 57.1 percent, the OIG rated the compliance component of this indicator ***inadequate.***

Compliance Testing Results

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

- Registered nurses (RN) demonstrated good performance in completing an initial assessment of the patient at the time of admission for all six sampled patients (MIT 13.001, 100%).
- Providers performed excellently in completing written history and physical examinations within the required time frames for all six sampled patients (MIT 13.002, 100%).
- Providers exhibited proficiency in ordering medications within the required time frames upon the patient's admission for all six sampled patients (MIT 13.003.1, 100%).

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

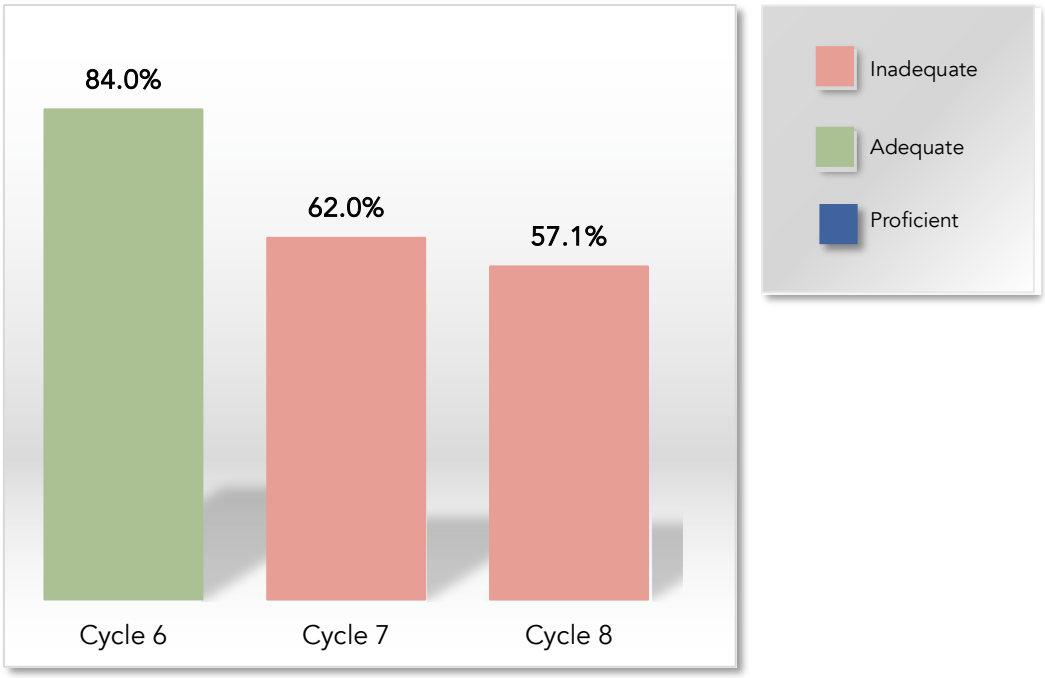
- Health care staff ensured all ordered medications were made available for only three of six sampled patients within the required time frames (MIT 13.003.2, 50.0%). For three patients, the pharmacy was not timely in filling and dispensing medications as ordered.
- Health care staff ensured all ordered medications were administered to the patient for only three of six sampled patients within the required time frames (MIT 13.003.3, 50.0%). For three patients, we found one or both of the following deficiencies: nursing staff did not administer nurse administered (NA) medications within the provider's ordered timelines or the record contained no evidence showing whether the patient refused or received medication.

- The institution did not maintain an operational call light system during the onsite inspection (MIT 13.101, zero). Specifically, during our inspection of the Correctional Treatment Center (CTC), the CTC nursing staff explicitly confirmed to our inspectors that the call light system for two specific rooms they identified was not functioning properly. They reported the system activated audible ringing even when the patients were not using the system. As a result, the nurses were not able to determine when the patients actually activated the system, because the system failed to provide an accurate localized visible and audible signal at the nurse's station indicating the specific room of origin when a patient activated the system, as required by California Code of Regulations, title 22, section 79839. Upon further inquiry to verify this malfunction, our inspectors spoke with LAC plant operations electricians, who were subsequently called out to evaluate the malfunction. The electricians informed our inspectors they discovered the call light system had been unplugged, and the CTC health care staff reported to them they unplugged the system due to the audible ringing from the two malfunctioning rooms. We reported this concern immediately to LAC health care leadership.

- LAC maintained a local operating procedure to conduct safety checks and rounds when the call light system is in disrepair. As discussed above, at the time of inspection, the call light system was non-operational for two patient rooms, and CTC nursing staff explained they were conducting rounding in lieu of the call light system. However, a review of the unit's tracking documentation revealed missing entries for the safety rounds required of the nursing staff when the call light system is not functioning properly (MIT 13.102, zero).

Analysis of Performance Across Inspection Cycles

Figure 9. Specialized Medical Housing, Compliance Scores Across Cycles



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

In Cycle 8, LAC continued to perform below established standards. The institution did not meet the 75.0 percent passing compliance threshold for this indicator, reaching only 57.1 percent in Cycle 8. This score demonstrates a further decline from the 62.0 percent recorded in Cycle 7 and remains significantly lower than the 84.0 percent achieved in Cycle 6, highlighting a critical and ongoing need for improvement in this indicator.

Table 25. Specialized Medical Housing Compliance Test Scores

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001)	6	0	0	100%
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)	3	3	0	50.0%
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)	3	3	0	50.0%
For specialized health care housing: Do specialized health care housing maintain an operational call system? (13.101)	0	1	0	0
For specialized health care housing): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	1	0	0
			Overall percentage (MIT 13):	**57.1%**

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

Compliance Recommendations

- Health care leadership should determine the root cause of challenges regarding inconsistent medication for specialized medical housing patients. Leadership should implement and monitor remedial measures as appropriate.
- Health care leadership should determine the root cause of equipment failures within the call light system and the inconsistent documentation of safety rounds by nursing staff. Leadership should implement and monitor remedial measures to ensure system functionality and complete compliance with tracking logs.

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 LAC performed satisfactorily in delivering specialty services to its patients. Specialty service appointments almost always occurred timely. Providers referred their patients to specialists and usually followed their treatment recommendations and requests for follow up appointments. Nurses generally assessed patients appropriately after specialty appointments. However, staff performed poorly in timely scanning specialty service reports. After reviewing and considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Case Review Results

Table 26. Case Review Specialty Services Results

Specialty Services Related Events*	Deficiencies†	Significant Deficiencies‡
184	35	14

* The OIG reviewed 184 events, including142 specialty consultations and procedures, 41 nursing encounters, and one provider encounter. Of the 184 events, patients refused 35 scheduled specialty encounters.

† Deficiencies occurred in cases 1, 9, 10, 13, 15, 19–22, 25, 26, 59, and 60.

‡ Significant deficiencies occurred in cases 1, 10, 13, 20, 22, 25, 26, and 59.

Performed Well

OIG clinicians found LAC performed well in the following area:

- Access to Specialty Services[82]

Performed Satisfactorily, with Opportunities for Improvement:

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

- Nursing Performance[83]

  Nurses usually performed satisfactorily in completing assessments, reviewing specialists' recommendations, and contacting the providers as needed when patients returned from off-site specialty appointments. Although we identified lapses in thorough nursing assessments, they did not significantly impact patient care. The following are examples of significant deficiencies:

  - In case 22, the patient returned from an off-site specialty chemotherapy appointment and complained of lower abdominal pain. The nurse did not perform a thorough abdominal assessment to include listening to bowel sounds, describing the abdomen, palpating the abdomen for tenderness, or documenting the last bowel movement.

  - In case 59, the patient returned from an off-site specialty iron infusion appointment. The patient complained of diarrhea; however, the nurse did not assess the onset of diarrhea or the frequency of episodes. In addition, the nurse did not listen to abdominal sounds or palpate the patient's abdomen for tenderness.

- Provider performance

  Providers performed sufficiently in ordering specialty services as well as following and addressing specialists' recommendations. Providers usually endorsed specialty reports timely. However, OIG clinicians identified four deficiencies in which the provider either

[82] OIG clinicians found almost all specialty appointments occurred within the requested time frames. We reviewed 100 specialty appointments and identified one late appointment, which was not significant. The one late appointment occurred in case 60.

[83] Fourteen nursing performance deficiencies occurred in cases 9, 19, 20–22, and 59, two of which were significant.

did not address the specialist recommendation or did not order an appropriate specialty services referral.[84] The following are examples:

- In case 8, the patient refused a gastroenterology specialty referral, and the nurse informed the provider of this refusal in the EHRS. However, the provider did not determine or document whether this specialty referral should have been re-ordered.
- In case 10, the optometrist evaluated the patient and recommended a follow-up appointment in three months to check eye pressures. The provider endorsed the optometrist report but did not order the follow up appointment with the optometrist.

Performed Poorly, Improvement Needed

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

- Health Information Management

  LAC staff performed poorly in managing specialty service reports. We identified nine deficiencies.[85] Of the nine deficiencies, three related to scanning documents late, two related to records not received, two related to poor legibility of specialist reports, one related to a specialty services report that was not sent to the provider for endorsement, and one related to the provider not sending the specialty test result to the patient. The following are examples:

  - In case 20, LAC staff scanned a radiation oncology treatment report 19 days late.
  - In case 26, LAC staff delayed retrieving the results report from a specialty echocardiogram study for nine days after the specialist electronically signed and made the report available, and delayed scanning the report for an additional day, which could have delayed critical cardiac care for this patient.
  - In case 26, the neurosurgeon evaluated the patient. However, the institution did not scan a legible dictated neurosurgeon report into the EHRS.

  We also discuss specialty service reports in the **Health Information Management** indicator.

[84] Seven deficiencies occurred in cases 8, 10, 15, 22, and 25. Three significant deficiencies occurred in cases 10, 22, and 25.
[85] Deficiencies occurred in cases 13, 20, 21, 25, and 26.

Clinician On-Site Inspection

LAC leadership reported LAC provides a wide range of on-site specialty services, including general surgery, urology, orthopedics, ophthalmology, physical therapy, optometry, audiology, podiatry, speech therapy, and occupational therapy. On average, LAC staff schedules approximately 15 on-site specialty appointments each day.

Photo 15. Physical therapy equipment. Photographed on 3-22-2026.

Photo 16. Physical therapy equipment. Photographed on 3-22-2026.

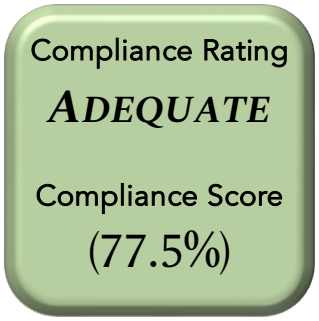
For off-site specialty services, specialty nurses work in the same trailer offices as the UM nurse. Leadership stated this close proximity helps improve communication and coordination of off-site specialty appointments. Specialty nurses stated they collaborate closely with the UM nurse to schedule appointments, particularly for specialties that are difficult to obtain, such as ophthalmology and neurosurgery. LAC has dedicated custody staff responsible for patient transportation, and custody staff occasionally transport patients to specialty appointment locations far away from LAC, such as to the Riverside University Health System. LAC maintains a fleet of vehicles to support the timely completion of approximately 25 off-site specialty appointments per day.

In addition, LAC has specific offices for telemedicine specialty services. Specialty nurses are responsible for ensuring the telemedicine equipment is functioning properly and all necessary laboratory results and imaging reports are available for specialists to review before appointments.

Case Review Recommendations

- Health care leadership should develop, implement, and monitor strategies to ensure staff timely scan all specialty service reports into the EHRS.

Specialty Services: Compliance Ratings and Results Summary



LAC performed satisfactorily in this indicator. Based on the overall compliance score result of 77.5 percent, the OIG rated the compliance component of this indicator ***adequate***.

LAC 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 14 of 15 patients (MIT 14.001, 93.3%). For one patient, the service was provided one day late.
- The institution achieved proficiency in ensuring providers review the high-priority specialty service consultant report within the required time frames all 14 applicable sampled patients (MIT 14.002.2, 100%).
- The institution timely provided subsequent follow-up appointments after a high-priority specialty service for all 11 applicable sampled patients (MIT 14.003, 100%).
- 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 proficient performance in ensuring providers review the medium-priority specialty service consultant report within the required time frames for all 13 applicable sampled patients (MIT 14.005.2, 100%).
- The institution ensured patients timely received their routine-priority specialty services within 90 calendar days for 13 of 15 patients (MIT 14.007, 86.7%). For two patients, the services were provided between 22 and 27 days late.
- The institution achieved proficient performance in ensuring providers review the routine-priority specialty service consultant report within the required time frames for all 15 sampled patients (MIT 14.008.2, 100%).

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

- The institution performed satisfactorily in providing subsequent follow-up appointments after a routine-priority specialty service for seven of nine sampled patients (MIT 14.009,

77.8%). For two patients, the follow-up appointment occurred between five and 28 days late.

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

- The institution received high-priority specialty service consultant reports within the required time frames for six of 15 applicable sampled patients (MIT 14.002.1, 40.0%). For eight patients, the reports were received between one and nine days late. For the remaining patient, the record contained no evidence the institution received the specialist report.

- The institution received medium-priority specialty service consultant reports within the required time frames for four of 11 applicable sampled patients (MIT 14.005.1, 36.4%). For five patients, the reports were received between five and 10 days late. For two patients, the record contained no evidence the institution received the specialist report.

- The institution provided timely subsequent follow-up appointments after a medium-priority specialty service for four of seven applicable sampled patients (MIT 14.006, 57.1%). For one patient, the refusal form was not completed on the day the patient refused the specialty service. For one patient, the provider failed to document whether they agreed or disagreed with the specialists' recommendations, as required by policy. For the remaining patient, the record contained no evidence of a signed refusal form for the refused follow-up specialist appointment.

- The institution received routine-priority specialty service consultant reports within the required time frames for 10 of 15 sampled patients (MIT 14.008.1, 66.7%). For five patients, the reports were received between two and 31 days late.

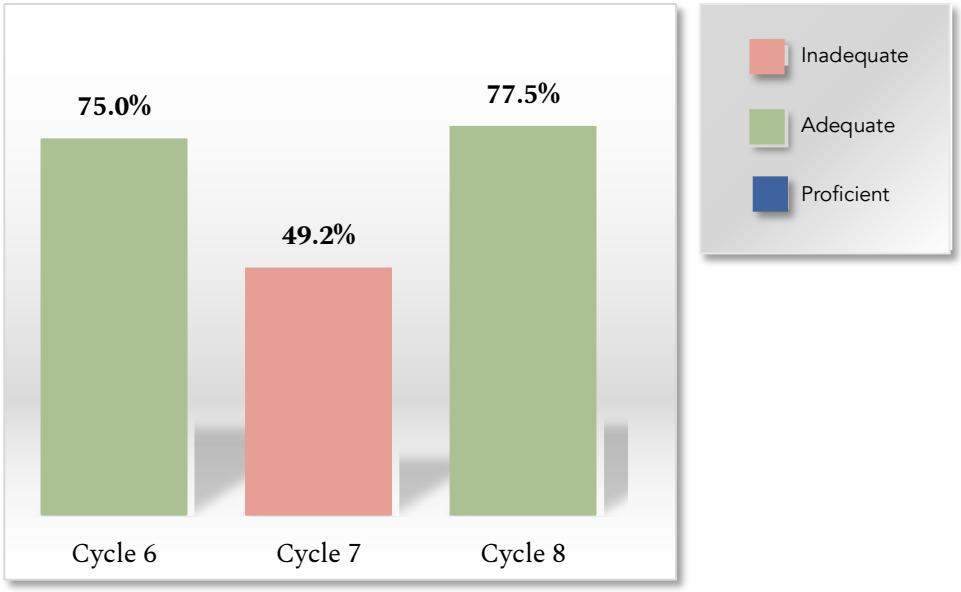
- The institution ensured patients timely received their pre-approved specialty service appointments for patients endorsed from another institution in only 10 of 20 sampled patients (MIT 14.010, 50.0%). For 10 patients, we found the following deficiencies: the services were provided 13 and 39 days late; the refusal form was not completed on the day the patient refused the specialty service; 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.

The following tests are not scored but are reported for informational purposes:

- The tests under this indicator for MITs 14.011 and 14.012 were deemed not applicable during the reporting period as we did not have enough samples meeting testing criteria for timely denial and communication of provider request for specialty services (MIT 14.011 & MIT 14.012, N/A).

Analysis of Performance Across Inspection Cycles

Figure 10. Specialty Services, Compliance Scores Across Cycles



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

In Cycle 8, LAC met established standards, improving from ***inadequate*** in Cycle 7 to ***adequate*** in Cycle 8. The institution met the 75.0 percent passing compliance threshold for this indicator, reaching 77.5 percent in Cycle 8. Although LAC's performance decreased from 75.0 percent in Cycle 6 to 49.2 percent in Cycle 7, the institution significantly improved, now performing in the ***adequate*** range again in Cycle 8.

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)	14	1	0	93.3%
Did the institution receive the high-priority specialty service consultant report within the required time frame? (14.002.1)	6	9	0	40.0%
Did the institution review the high-priority specialty service consultant report within the required time frame? (14.002.2)	14	0	1	100%
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)	11	0	4	100%
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)	4	7	4	36.4%
Did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005.2)	13	0	2	100%
Did the patient receive the subsequent follow-up to the medium- priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.006)	4	3	8	57.1%
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)	13	2	0	86.7%
Did the institution receive the routine-priority specialty service consultant report within the required time frame? (14.008.1)	10	5	0	66.7%
Did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008.2)	15	0	0	100%
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)	7	2	6	77.8%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	10	10	0	50.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	N/A	N/A	N/A	N/A
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 14): **77.5%**

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

Compliance Recommendations

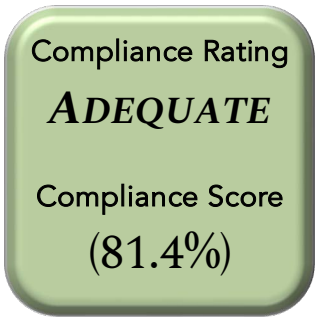
- The department should develop measures to ensure institutions timely receive specialty reports. Department leadership should implement and monitor remedial measures as appropriate.
- The institution's health care leadership should develop strategies to ensure patients timely receive pre-approved or 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



LAC performed satisfactorily in this indicator. Based on the overall compliance score result of 81.4 percent, the OIG rated this indicator ***adequate***.

Compliance Testing Results

LAC 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 nine of 10 sampled patients (MIT 15.102, 90.0%). For one patient, the report was not completed within the required timeframe.

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

- All 14 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%).

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

- The medical leadership completed five of the nine clinicians' performance appraisals timely (MIT 15.104, 55.6%). For four appraisals, the medical leadership failed to provide a complete Ongoing Professional Practice Evaluation (OPPE) timely.

- The institution ensured health care educators properly completed and documented the required onboarding and clinical competency processes for three of 15 newly hired nurses (MIT 15.108, 20.0%). For 12 nurses, inspectors found the Nursing Civil Service Onboarding Checklists incomplete for one or both of the following reasons: the form lacked employees' signatures and initials or lacked an identified nursing instructor's signature. For the latter deficiency, the training forms identified two different nursing instructors initials on the training forms indicating two different instructors provided portions of the training such that both educators were required to sign the form validating their portions of the training. However, in each case, only one instructor signed and validated their portion of the training.

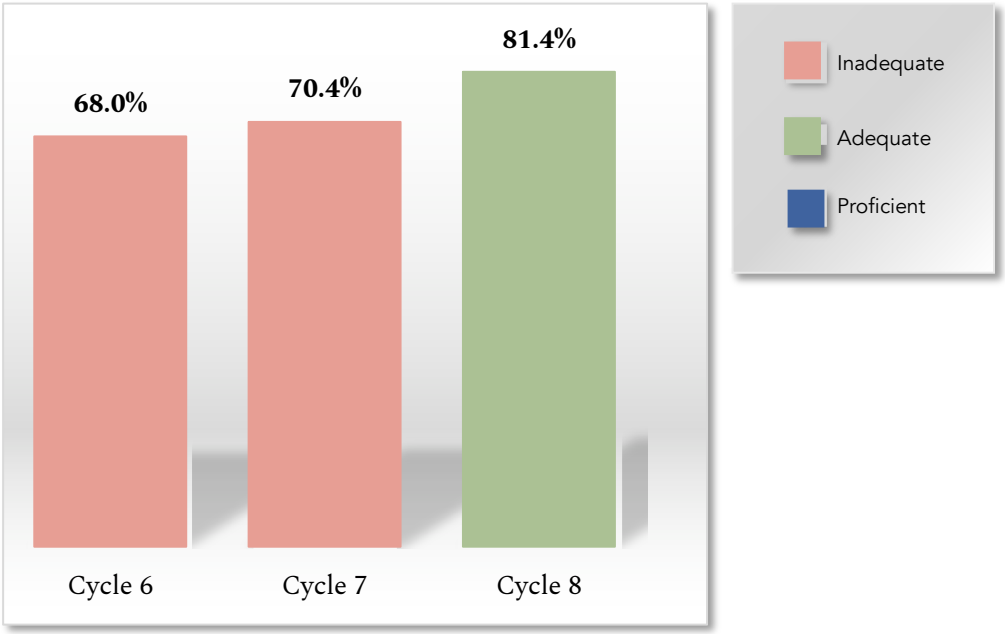
- We obtained LAC's CCHCS Mortality Case Review reporting data. The institution's CEO and their designees fully completed the multidisciplinary review of the significant events leading to only three of 10 patient deaths during our review period (MIT 15.998 [scored component], 30.0%). The institution failed to document the completion date on their Institution Mortality Reviews for seven patient deaths to match all requirements of the Institution Death Review Summary forms. Consequently, these Mortality Case Reviews are incomplete for purposes of this test.

The following tests are not scored but are reported for informational purposes:

- At LAC, the OIG did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001, N/A).
- For the other portion of the mortality review testing, we found no evidence in the submitted documentation the preliminary mortality reports were completed for eight of 10 patient death reports. For the remaining two 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 LAC Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, LAC met established standards, improving from ***inadequate*** in Cycle 7 to ***adequate*** in Cycle 8. The institution exceeded the 75.0 percent passing compliance threshold for this indicator, reaching 81.4 percent in Cycle 8. This reflects steady progress from 68.0 percent in Cycle 6 and 70.4 percent in Cycle 7, demonstrating a successful commitment to improvement.

Table 28. Administrative Operations Compliance Test Scores

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For informational purposes only: For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This test is not scored. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.003)	4	0	0	100%
Did the responses to medical grievances address all of the patients' appealed issues? (15.101)	10	0	0	100%
Did the medical staff review and submit initial patient death reports timely? (15.102)	9	1	0	90.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.103)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.104)	5	4	0	55.6%
Did the providers maintain valid state medical licenses? (15.105)	14	0	0	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.106)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.107)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.108)	3	12	0	20.0%
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)?	3	7	0	30.0%
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This test is not scored. Please refer to Table x for CCHCS- provided staffing information.			
Overall percentage (MIT 15): **81.4%**				

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

Compliance Recommendations

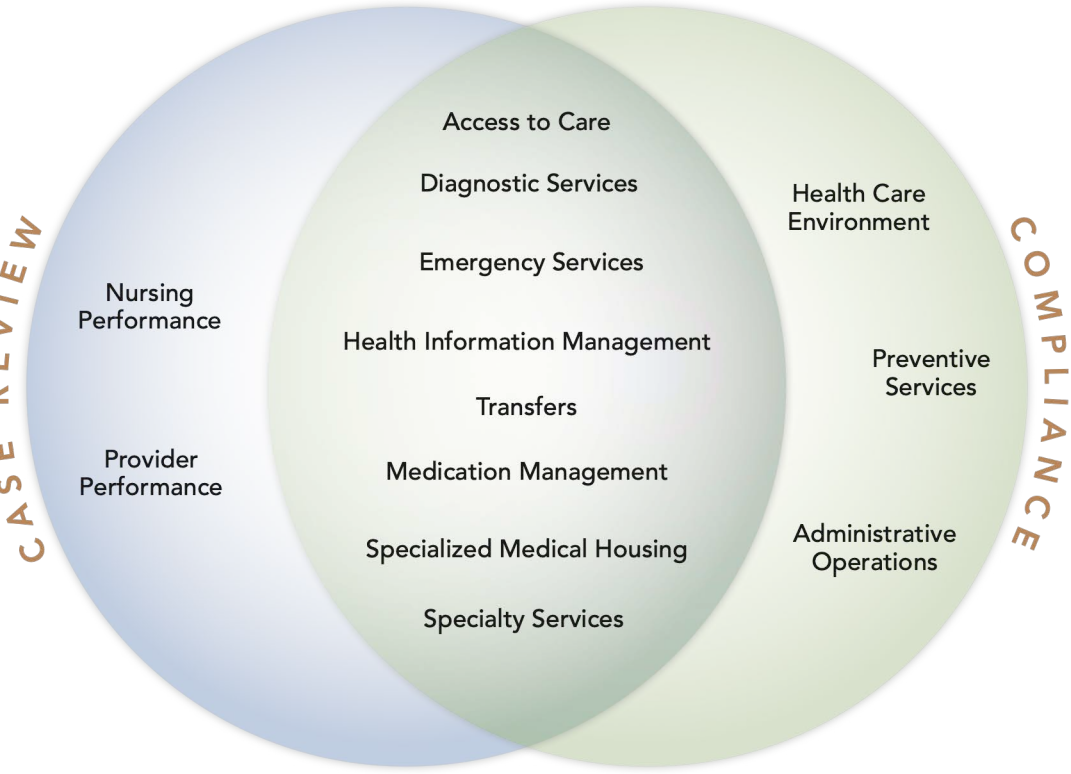
The OIG offers no recommendations for this indicator.

Appendix A: Methodology[86]

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

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure 8 below depicts the intersection of case review and compliance.

Figure 12. Inspection Indicator Review Distribution for LAC



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 7 medical inspections. Below, Table 29 provides important definitions that describe this process.

Table 29. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

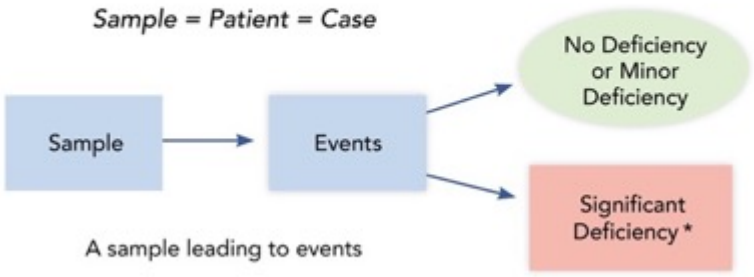
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review *events*. Our clinicians also record medical errors, which we refer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

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an *adverse event*. On the next page, Figure 13 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.

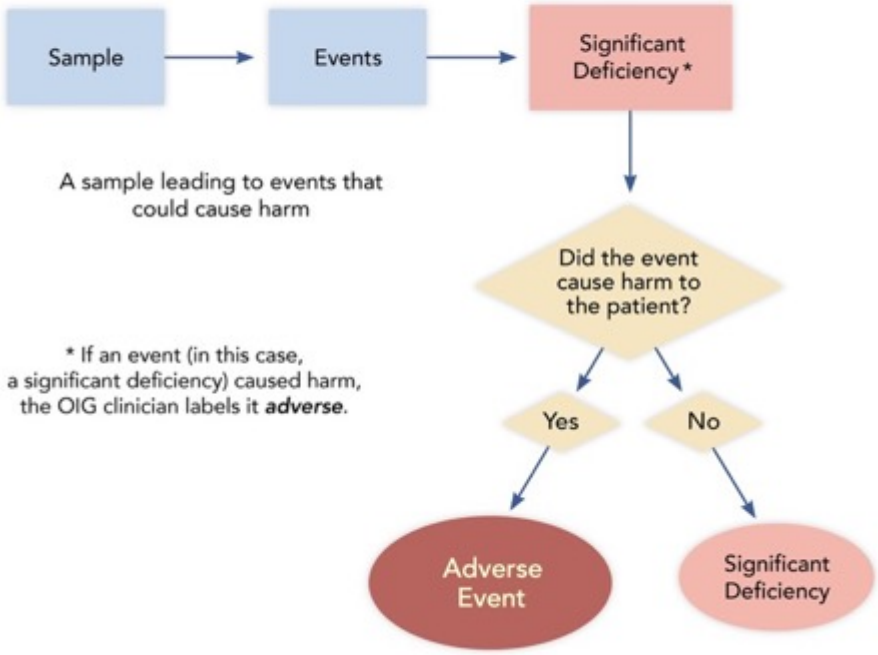
Figure 13. Case Review Testing

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. LAC Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	2
Emergency Services – Non-CPR	3
High Risk	4
Hospitalization	3
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	24
Specialty Services	4
	60

Table 31. LAC Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	7
Anticoagulation	7
Arthritis/Degenerative Joint Disease	2
Asthma	12
COVID-19	1
Cancer	4
Cardiovascular Disease	5
Chronic Kidney Disease	2
Chronic Pain	18
Cirrhosis/End-State Liver Disease	4
Coccidiomycosis	3
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	9
Gastroesophageal Reflux Disease (GERD)	16
HIV	4
Hepatitis C	17
Hyperlipidemia	26
Hypertension	22
Mental Health	30
Migraine Headaches	2
Seizure Disorder	5
Sleep Apnea	3
Substance Abuse	28
Thyroid Disease	2
	230

Table 32. LAC Case Review Events by Program

Diagnosis	Total
Diagnostic Services	178
Emergency Care	79
Hospitalization	29
Intrasystem Transfers In	8
Intrasystem Transfers Out	7
Outpatient Care	410
Specialized Medical Housing	103
Specialty Services	232
	1,046

Table 33. LAC Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	25
MD Reviews Focused	3
RN Reviews Detailed	17
RN Reviews Focused	35
Total Reviews	80
Total Unique Cases	60
Overlapping Reviews (MD & RN)	20

Appendix C: Compliance Sampling Methodology

California State Prison, Los Angeles County

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	Chronic care conditions (at least one condition per patient—any risk level) Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	Clinic (each clinic tested) Appointment date (1–7 months) Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	Appointment date (30 days–7 months) Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
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
Emergency Services				
MIT 3.001	EMRRC	12	EMRRC meeting minutes	Monthly meeting minutes (6 months)
MITs 3.101 - 103	Clinical Areas	10	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 3.105	Medical Emergency Response Certifications	All	On-site certification tracking logs	All staff Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	Non-dictated documents First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	Specialty documents First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	25	OIG Q: 4.005	Community hospital discharge documents First 20 IPs selected
MIT 4.004	Scanning Accuracy	25	Documents for any tested incarcerated person	Arrival date (12 months) Any misfiled or mislabeled document identified during OIG compliance review Randomize
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site admissions	Date (1–7 months) Most recent 6 months provided (within date range) Rx count Discharge date

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	10	OIG inspector on-site review	Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	Arrival date (1–7 months) Arrived from (another departmental facility) Rx count Randomize
MIT 6.101	Transfers Out	0	OIG inspector on-site review	R&R IP transfers with medication
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See Access to Care At least one condition per patient—any risk level Randomize
MIT 7.002	New Medication Orders	25	Master Registry	Rx count Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				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	10	SOMS	Date of transfer (1–7 months) Sending institution (another departmental facility) Randomize NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	Identify and inspect clinical & med line

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	22	Medication error reports	All medication error reports Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	20	On-site active medication listing	KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	Delivery date (2–12 months) Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	Arrival date (2–12 months) Earliest arrivals (within date range)
Preventive Services				

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 9.001–002	TB Medications	18	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 9.007	Pap Smear	N/A at this institution	SOMS	Arrival date (at least three yrs. prior to inspection) Date of birth (age 21 – 65) Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	Chronic care conditions (at least 1 condition per IP—any risk level) Randomize Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	Reports from past 2–8 months Institution Ineligibility date (60 bus days prior to inspection date) All
Reception Center				
MITs 12.001–007	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)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				Length of stay (minimum of 5 days) Rx count Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	Specialized Health Care Housing Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	Approval date (3–9 months) Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender services Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	Approval date (3–9 months)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				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,

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				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	0	InterQual	Review date (3–9 months) Randomize
		N/A	IUMC/MAR Meeting Minutes	Meeting date (9 months) Denial upheld Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	Adverse/Sentinel events (12 months)
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)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters	
MIT 15.101	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	Medical grievances closed (6 months)	
MIT 15.102	Death Reports	10	Institution-list of deaths in prior 12 months	Most recent 10 deaths Initial death reports	
MIT 15.103	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	9	On-site provider evaluation files	All required performance evaluation documents	
MIT 15.105	Provider Licenses	14	Current provider listing (at start of inspection)	Review all	
MIT 15.106	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	All required licenses and certifications	
MIT 15.107	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	All DEA registrations	
MIT 15.108	Nursing Staff New Employee Orientations	All	Nursing staff training logs	New employees (hired within last 12 months)	
MIT 15.998	CCHCS Mortality Case Review	10	OIG summary log: deaths	Between 35 business days & 12 months prior	

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
				California Correctional Health Care Services mortality reviews

California Correctional Health Care Services' Response

Docusign Envelope ID: D4E399C5-9CAA-8859-8383-81D54D0ECA46

August 6, 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 California State Prison, Los Angeles County. Thank you for preparing the report.

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

Sincerely,

Signed 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
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Rainbow Brockenborough, Deputy Director, Institution Operations, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region IV, CCHCS
Chief Executive Officer, LAC
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Amanda Elhardt, Report Coordinator, OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

Cycle 8

Medical Inspection Report

for

California State Prison

Los Angeles County

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2026

OIG