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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

August 2026

Wasco State Prison

Medical Inspection Report

Cycle 8

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Introduction

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

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

Specifically, in conducting in-depth, quality-focused reviews of randomized cases, our case review clinicians examine whether health care staff used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient. At the same time, our clinicians consider whether institutional medical processes led to identifying and correcting individual or systemic errors, and we examine whether the institution's medical system mitigated the error. In addition, our clinicians also perform on-site inspections, which include interviews with staff.

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

Together, these methods assess the institution's medical care on both individual and systemic levels by providing an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk, who tend to access services at the highest rate. Through these methods, the OIG evaluates the performance of the institution in providing sustainable, adequate care. Similarly to Cycle 7, the OIG separately rates the institution's health care delivery through both our clinical case review and compliance testing for each applicable indicator as ***proficient***, ***adequate***, or ***inadequate***, and considers each rating in determining the case review and compliance overall ratings of the institution's health care performance. We found this

[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.

change in Cycle 7 clarified the distinctions between these differing quality measures and the results of each assessment.

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, "**MIT 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 Wasco State Prison, the institution had been delegated back to the department by the receiver (2022).

We completed our eighth inspection of Wasco State Prison, 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 from MIT 5. Health Care Environment and MIT 15. Administrative Operations 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 distinguish 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 October 2025 to March 2026, as well as on-site observations during April 2026 and May 2026; however, the OIG may review samples outside the general inspection period as dictated by our methodologies. The case reviews include death reviews between June 2025 and February 2026 and specialized medical housing reviews between April 2025 and February 2026.

Summary: Ratings and Scores

We completed the Cycle 8 inspection of Wasco State Prison (WSP) in May 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 WSP as ***adequate***.

The OIG rated the compliance component of the overall health care quality at WSP as ***adequate*** (**78.0%**).

OIG case review clinicians—a team of Physicians & Surgeons (physicians) and Nursing Consultants, Program Review (NCPRs)—reviewed 50 cases, which contained 555 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 May 2026 to verify their initial findings. OIG clinicians evaluated the quality of care for a total of 66 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.[9]

To evaluate the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies set forth in the

[8] For our detailed and focused case reviews, our clinicians reviewed medical charts and events for 50 unique patients. Both physicians and NCPRs reviewed 16 of those cases, for a total of 66 detailed and focused case reviews.

[9] For a further discussion of an adverse event, see Table 31.

department's Health Care Department Operations Manual (HCDOM)[10] by applying a standardized set of test questions that measure specific elements of health care delivery as required under the HCDOM. Our compliance inspectors examined 437 patient records and 1,340 data points, and we used the data to assess 110 MIT questions. We also observed WSP's processes during an on-site inspection in April 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 14 health care indicators.[11]

Overall Medical Inspection Results

Case Review Results

OIG case reviewers assessed 11 of the 14 indicators applicable to WSP. OIG clinicians rated two of these 11 indicators ***proficient***, eight ***adequate***, and one ***inadequate***. In the 555 events reviewed, we identified 190 deficiencies, 57 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 WSP during the Cycle 8 inspection.

Compliance Testing Results

Our compliance inspectors assessed 12 of the 14 indicators applicable to WSP. Of these 12 indicators, our compliance inspectors rated four ***proficient***, four ***adequate***, and four ***inadequate***. We solely tested policy compliance in **Health Care Environment**, **Preventive Services**, and **Administrative Operations** as these indicators do not have a case review component.

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

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

[11] The indicator ***Prenatal and Postpartum Care*** did not apply to WSP.

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

MIT Number	Health Care Indicators	Case Review Cycle 8	Case Review Change Since Cycle 7*	Compliance Cycle 8	Compliance Cycle 7	Compliance Change Since Cycle 7*
		Ratings: Proficient, Adequate, Inadequate		*Scoring Ranges*: 100%–85.0%, 84.9%–75.0%, 74.9%–0		
1	Access to Care	Proficient	=	77.1%	82.1%	=
2	Diagnostic Services	Adequate	=	72.3%	60.8%	=
3	Emergency Services	Adequate	=	31.3%	N/A	N/A
4	Health Information Management	Adequate	↑	92.7%	83.6%	↑
5	Health Care Environment	N/A	N/A	83.7%	43.2%	↑
6	Transfers	Adequate	=	68.7.%	78.3%	↓
7	Medication Management	Adequate	=	70.7%	49.6%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	85.7%	78.5%	↑
10	Nursing Performance	Adequate	↑	N/A	N/A	N/A
11	Provider Performance	Adequate	↑	N/A	N/A	N/A
12	Reception Center	Proficient	↑	84.4%	70.4%	↑
13	Specialized Medical Housing	Inadequate	=	96.1%	85.0%	=
14	Specialty Services	Adequate	↑	84.3%	81.7%	=
15	Administrative Operations	N/A	N/A	89.0%	74.9%	↑↑

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

* 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 the rating did not change from the previous cycle (***inadequate***, ***adequate***, or ***proficient***). The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels.

Institution-Specific Metrics

Wasco State Prison (WSP), located in Wasco, Kern County, houses medium-custody general population, reception center, and minimum-custody incarcerated people. At the time of our inspection, the incarcerated population was 3,466. WSP is designated as a ***reception center***, providing general outpatient health care services through its 11 clinics, which handle nonurgent requests for medical services. Patients needing urgent or emergent care are treated in its triage and treatment area (TTA), and inpatient health services in its correctional treatment center (CTC).[12]

In February 2026, the Health Care Services Master Registry showed WSP had a total population of 3,466. A breakdown of the medical risk level of the WSP population as determined by the department is set forth in Table 2 below.[13]

Table 2. WSP Master Registry Data as of February 2026

Medical Risk Level	Number of Patients	Percentage*
High 1	45	1.3%
High 2	149	4.3%
Medium	1,729	49.9%
Low	1,543	44.5%
Total	**3,466**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated February 9, 2026.

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, WSP had 2.0 vacant executive leadership positions, 8.0 primary care provider vacancies, 0.2 nursing supervisor vacancies, and 4.1 nursing staff vacancies.

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

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

Table 3. WSP Health Care Staffing Resources as of February 2026

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	11.0	14.2	157.1	187.3
Filled by Civil Service	3.0	3.0	14.0	153.0	173.0
Vacant	2.0	8.0	0.2	4.1	14.3
Percentage Filled by Civil Service	60.0%	27.3%	98.6%	97.4%	92.4%
Filled by Telemedicine	0.0	0.0	0.0	0.0	0.0
Percentage Filled by Telemedicine	0.0%	0.0%	0.0%	0.0%	0.0%
Filled by Registry	0.0	0.0	0.0	0.0	0.0
Percentage Filled by Registry	0.0%	0.0%	0.0%	0.0%	0.0%
Total Filled Positions	3.0	3.0	14.0	153.0	173.0
Total Percentage Filled	60.0%	27.3%	98.6%	97.4%	92.4%
Appointments in Last 12 Months	29.0	0.0	0.0	0.0	29.0
Redirected Staff	0.0	0.0	0.0	0.0	0.0
Staff on Extended Leave‡	0.0	0.0	0.0	0.0	0.0
Adjusted Total: Filled Positions	3.0	3.0	14.0	153.0	173.0
Adjusted Total: Percentage Filled	60.0%	27.3%	98.6%	97.4%	92.4%

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 8 medical inspection pre-inspection questionnaire received on February 9, 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 WSP'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 and Kaiser Permanente—WSP'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. WSP had a 26 percent influenza immunization rate for adults 18 to 64 years old and an N/A influenza immunization rate for adults 65 years of age and older. The pneumococcal immunization rate was also N/A, see Table 4 for more information.

Cancer Screening

Statewide comparative data was available for colorectal cancer screening. When compared with statewide Medi-Cal programs—California (Medi-Cal), and—Kaiser Permanente — WSP had a 66 percent colorectal cancer screening rate, a rate higher and thus better than California Medi-Cal but lower than Kaiser Permanente.

Table 4. WSP Results Compared to State HEDIS Scores

HEDIS Measure	WSP Cycle 8 Results*	California Medi-Cal†	Kaiser Permanente†
Diabetic Population			
Poor HbA1c Control (>9.0%) ‡, §	**15%**	29%	20%
HbA1c Control (<8.0%) ‡	59%	–	–
Blood Pressure Control (<140/90) ‡	89%	–	–
HbA1c Screening	100%	–	–
Eye Exams	74%	–	–
Immunizations			
Influenza - Adults (18–64)	26%	–	–
Influenza - Adults (65+) **	N/A	–	–
Pneumococcal – Adults (65+) **	N/A	–	–
Cancer Screening			
Colorectal Cancer Screening	66%	40%	**79%**

* Unless otherwise stated, data were collected in March 2026 by reviewing medical records from a sample of WSP'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 WSP population was tested.

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

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

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, OIG clinicians found WSP performed effectively in delivering access to care for its patients. WSP providers timely evaluated all patients in the outpatient clinics, specialized medical housing, and reception center. The providers also timely completed all follow-up appointments after hospitalizations, specialty services, and patients transferred into WSP as well as most follow-up appointments after emergent events. In addition, WSP completed most nursing appointments without delays. However, while WSP performed satisfactorily with access to specialists, we identified some opportunities for improvement. 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‡
50	4	2

* The OIG reviewed 50 cases.

† Deficiencies occurred in cases 2, 7, 8, and 30.

‡ Significant deficiencies occurred in cases 7 and 30.

Performed Well

OIG clinicians found WSP performed well in the following areas:

- Access to Clinic Providers[14]
- Access to Specialized Medical Housing Providers[15]
- Follow-up after Hospitalizations[16]
- Follow-up after Specialty Services[17]
- Follow-up after Transferring into WSP[18]
- Follow-up after Urgent and Emergent Care[19]
- Access to Clinic Nurses[20]

Performed Satisfactorily with Opportunities for Improvement

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

- Access to Specialty Services

  WSP generally performed well ensuring access to specialty services. However, the OIG clinicians identified two significant deficiencies, one of which is described as follows:[21]

  - In case 7, a provider requested an optometry appointment to occur in two weeks. However, the appointment occurred seven weeks late.

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

Performed Poorly, Improvement Needed

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

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[14] OIG clinicians identified no deficiencies in this subindicator.

[15] OIG clinicians identified no deficiencies in this subindicator.

[16] OIG clinicians identified no deficiencies in this subindicator.

[17] OIG clinicians identified no deficiencies in this subindicator.

[18] This subindicator included access to follow-up appointments for reception center patients. OIG clinicians identified no deficiencies in this subindicator.

[19] A minor deficiency occurred in case 8.

[20] A minor deficiency occurred in case 2.

[21] Significant deficiencies occurred in cases 7 and 30.

Clinician On-Site Inspection

OIG clinicians observed several huddles during our on-site inspection at WSP. In the clinics, the patient care teams discussed patients who were new to the clinics and patients who had upcoming clinic appointments with providers, nurses, and off-site specialists. The patient care teams were knowledgeable about their patients and reported no appointment backlogs. We spoke with specialty services nurses, scheduling supervisors, and the chief physician and surgeon (CP&S) about the deficiencies we identified. We also asked the providers, the CP&S, and the chief medical executive about cases we identified during our reviews in which the provider marked the appointment as "complete" instead of "canceled," but the EHRS did not indicate the complete appointment occurred. The providers and medical leadership stated they closed encounters as "completed" if the patient came to the clinic, spoke with the provider, and then refused to continue with the provider face-to-face appointment. However, during our reviews, we did not find any documentation of face-to-face encounters and refusals in the cases in which we identified these discrepancies.

Case Review Recommendations

The OIG offers no Case Review recommendations for this indicator.

Access to Care: Compliance Ratings and Results Summary

Compliance Rating
ADEQUATE
Compliance Score
(77.1%)

WSP performed satisfactorily in this indicator. Based on the overall compliance score, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- When new patients arrive at the institution, the patients must either be assessed by an RN or evaluated by a provider, depending on their clinical risk level. Providers maintained their workflows and completed their comprehensive patient appointments for all 20 applicable sampled patients referred for provider appointment. (MIT 1.002, 100%).

- Following the review of the patients' submitted health care service request forms (CDCR Form 7362s), registered nurses (RNs) completed face-to-face appointments for 27 of 30 sampled patients within one business day (MIT 1.004, 90.0%). For two patients, the appointments occurred one day late. For the remaining patient, nursing staff did not document the visit using the required Subjective, Objective, Assessment, and Plan (SOAP) note format.

- Providers completed post-discharge follow-up appointments for 13 of 15 sampled patients within the required time frames (MIT 1.007, 86.7%). For one patient, the record contained no evidence the appointment occurred. For the remaining patient, the record contained no evidence a refusal form for a follow-up appointment after hospitalization was completed during our review period.

- The institution implemented a standardized process for the acquisition and submission of CDCR Forms 7362 for all six housing units (MIT 1.101.2, 100%).

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

- In five applicable samples where an RN identified the need for a primary care referral, four patients were seen within the required time frames according to the priority level assigned to their appointment (MIT 1.005, 80.0%). For one patient,

the record contained no evidence the appointment occurred during our review period.

- The institution met mandated timelines well 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 (PCT) provided the required timely notification of the specialist's recommendations in 36 of 43 applicable sampled patients (MIT 1.008, 83.7%). For three patients, the primary care provider (PCP) follow-up appointment after a high-priority specialty service occurred between one and 14 days late. For two patients, the record contained no evidence of either a PCP or RN appointment following a medium-priority specialty service or a generated patient letter communicating the specific specialist recommendations within our review period. For the remaining two patients, the records contained no evidence the appointments occurred following a high- and medium-priority specialty service during our review period.

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

- The institution conducted the most recent chronic care appointments for 15 of 25 sampled patients within the specified time frames (MIT 1.001, 60.0%). For seven patients, the appointments occurred between one and 184 days late. For three patients, the record contained no evidence the appointment occurred.

- Nursing staff performed poorly in adhering to triage documentation standards; staff met the full requirements for a completed review upon receipt of the CDCR Form 7362 for only five of 30 sampled patients (MIT 1.003, 16.7%). For 25 patients, nursing staff failed to accurately complete the CDCR Form 7362 with the required receipt date and time, their printed or stamped name, their signature, and their title.

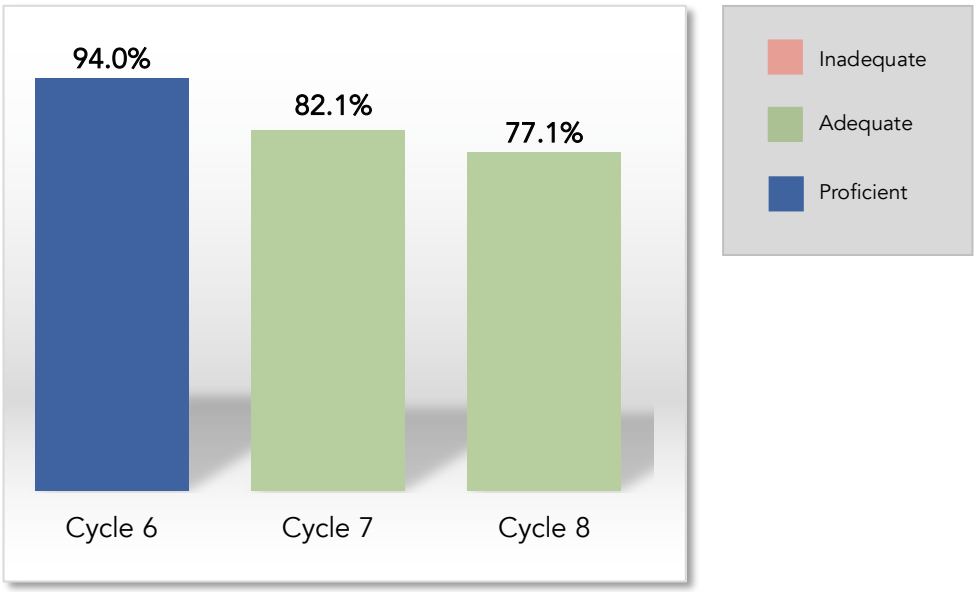
The following tests are not scored but are reported for informational purposes:

- The institution implemented a standardized process for the replenishment of CDCR Forms 7362, by which custody officers coordinated with the program office to ensure they maintained an adequate supply for all patients in the housing units (MIT 1.101.1, N/A).

- We deemed the compliance test in 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 WSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

WSP met the 75.0 percent passing compliance threshold in this indicator, maintaining an ***adequate*** performance of 77.1 percent in Cycle 8. While this score places WSP's performance within the ***adequate*** range, this score follows WSP's previous ***proficient*** score of 94.0 percent in Cycle 6 and higher ***adequate*** score of 82.1 percent 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**.

Compliance Score Results

Table 6. Access to Care Compliance Test Scores

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	15	10	0	60.0%
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)	20	0	5	100%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	5	25	0	16.7%
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	3	0	90.0%
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)	4	1	24	80.0%
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)	13	2	0	86.7%
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)	36	7	2	83.7%
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)	6	0	0	100%
Overall percentage (MIT 1): **77.1%**				

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 health care services requests (CDCR Forms 7362) and complete all required documentation. Leadership should implement and monitor remedial measures as appropriate.
- Health care leadership should determine the challenges to facilitating timely chronic care follow-up appointments with providers. 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 WSP performed satisfactorily with diagnostic services. Compared to Cycle 7, staff performed excellently in test completion. In addition, WSP providers received and endorsed diagnostic test results timely. However, similar to Cycle 7, providers often either did not send or sent incomplete test result notification 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‡
72	25	1

* The OIG reviewed 72 diagnostic events.

† Deficiencies occurred in cases 2, 7, 8, 10, 12–14, and 30. Of these 25 deficiencies, 24 related to health information management, none related to a provider's review of a test, and one related to a delay in diagnostic test completion.

‡ One significant deficiency occurred in case 14.

Performed Well

OIG clinicians found WSP performed well in the following area:

- Test Completion[22]

[22] A significant deficiency occurred in case 14 in which staff did not perform a laboratory test.

Performed Satisfactorily with Opportunities for Improvement

OIG clinicians found no areas in which WSP performed satisfactorily with opportunities for improvement.

Performed Poorly, Improvement Needed

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

- Health Information Management

  WSP's performance varied in managing diagnostic test results. WSP performed well in forwarding the test results to the providers for review, and the providers endorsed the results timely. However, we identified a pattern of 20 deficiencies related to missing required elements in the patient test result notification letters.[23] Providers also did not send letters in nine instances.[24] The following are examples:

  - In case 2, the provider endorsed laboratory test results. However, the provider did not generate a patient test results notification letter.
  - In case 7, a provider sent a patient test result notification letter. However, the letter did not include whether the results are unchanged, within normal limits, or as expected and did not state whether additional testing is required.

Clinician On-Site Inspection

OIG clinicians spoke with laboratory and radiology staff, as well as the diagnostics supervisor. Laboratory and radiology staff reported good work environments, where everyone worked well together. Radiology staff also reported their radiology technologist worked eight-hour shifts, and they had no appointment backlogs. We discussed the deficiency in which staff did not perform a laboratory test in case 14. The supervisor stated the phlebotomist expected the laboratory test to be drawn while the patient was on dialysis; however, this laboratory test did not occur.

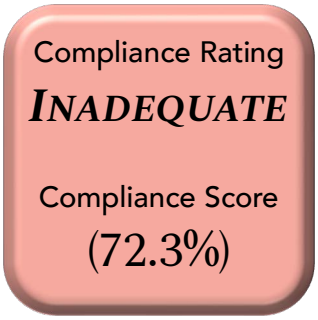
Case Review Recommendations

The OIG offers no Case Review recommendations for this indicator.

[23] Minor deficiencies occurred in cases 2, 7, 8, 10, 12–14, and 30.

[24] Minor deficiencies occurred in cases 2, 10, and 30.

Diagnostic Services: Compliance Ratings and Results Summary



WSP has opportunities for improvement in this indicator. Based on the overall compliance score, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

WSP 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 time frames (MIT 2.001, 100%).
- Providers demonstrated proficiency in reviewing and endorsing radiology reports for all 10 sampled patients (MIT 2.002, 100%).
- Providers demonstrated proficiency in timely reviewing and endorsing laboratory reports for all 10 sampled patients (MIT 2.005, 100%).
- The institution collected STAT (immediate) laboratory tests and received the results for nine of 10 sampled patients within the required time frames (MIT 2.007, 90.0%). For one patient, the institution did not collect or receive the result timely.
- Providers demonstrated proficiency in endorsing STAT laboratory results for all 10 sampled patients (MIT 2.009, 100%).
- WSP received pathology reports for seven of eight applicable sampled patients within required time frames (MIT 2.010, 87.5%). For one patient, the record contained no evidence of a pathology report received during our review period.
- Providers demonstrated proficiency in timely reviewing and endorsing pathology reports for all seven applicable sampled patients (MIT 2.011, 100%).

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

- Laboratory services consistently completed orders for eight of 10 sampled patients within the time frames specified (MIT 2.004, 80.0%). For two patients, the laboratory services ordered as timed and routine studies were not performed within the specified time frames.

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

- Healthcare providers generated patient notification letters for radiology reports with all required elements within specified time frames for only one of 10 sampled patients (MIT 2.003, 10.0%). For seven patients, the record contained no evidence of a generated patient letter communicating radiology results. For two patients, the patient letters were missing key elements as required by policy.

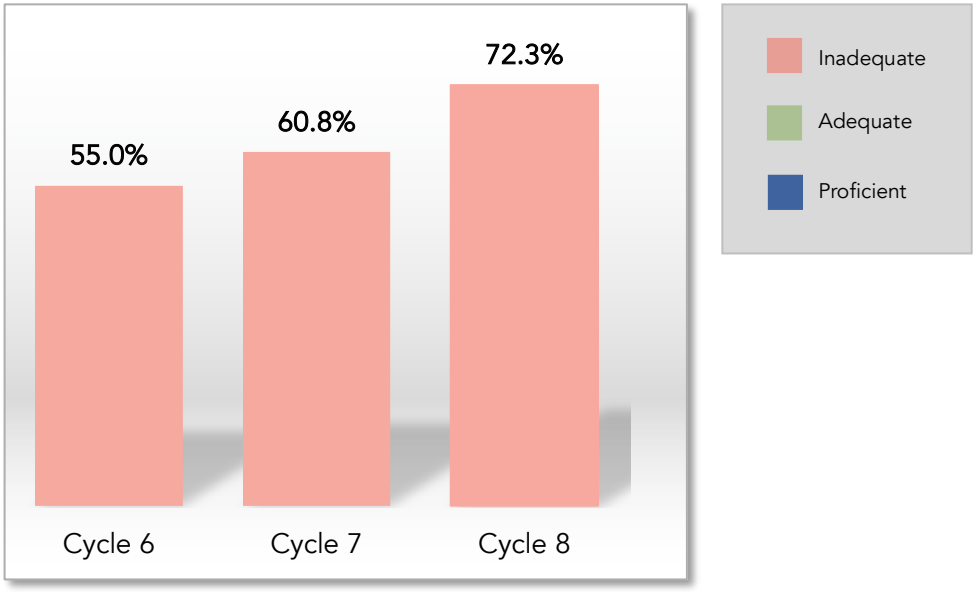
- Healthcare providers generated patient notification letters for laboratory reports with all required elements within specified time frames for seven of 10 sampled patients (MIT 2.006, 70.0%). For three patients, the patient letters were missing key elements as required by policy.

- The provider acknowledged the STAT test results, or the nursing staff notified the provider of the STAT test results, within the required time frames for three of 10 sampled patients (MIT 2.008, 30.0%). For seven patients, this required notification or acknowledgment did not occur within the specified time frames.

- Healthcare providers did not generate a patient notification letter with all required elements for pathology results in any of seven applicable sampled patients (MIT 2.012, zero).

Analysis of Performance Across Inspection Cycles

Figure 2. Diagnostic Services, Compliance Scores Across Cycles



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

Overall, the institution did not meet the 75.0 percent passing compliance threshold for diagnostic services, reaching only 72.3 percent in Cycle 8. While this score remains in the ***inadequate*** performance range, this score demonstrates significant improvement over the past three cycles in this indicator, increasing from lower ***inadequate*** scores of 55.0 percent in Cycle 6 and 60.8 percent in Cycle 7, to a nearly ***adequate*** score in this cycle.

Compliance Score Results

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)	1	9	0	10.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	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)	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008)	3	7	0	30.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	10	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	7	1	0	87.5%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	7	0	1	100%
Pathology: Did the health care provider generate the patient notification letter with all required elements within the specified time frame? (2.012)	0	7	1	0
Overall percentage (MIT 2): **72.3%**				

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

Compliance Recommendations

- The department should develop, implement, and monitor solutions, such as an electronic solution, to ensure providers timely communicate radiology, laboratory, and pathology results to the patients containing all required elements for explaining diagnostic results.
- Health care leadership should develop, implement, and monitor strategies to ensure staff adhere to departmental policy requirements for provider acknowledgement and nurse notification of STAT (immediate) laboratory results.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of urgent and emergent medical care. Our clinicians reviewed these events by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the healthcare leadership's ability to identify opportunities for improvement in the emergency medical response review process. Our clinicians 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 these measures 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 overall WSP provided good emergency care. Nurses performed well in providing CPR, promptly responded to emergency alarms, and usually provided sufficient care. Physicians appropriately triaged their patients, made accurate diagnoses, and documented their communication and decisions. The medical leadership regularly performed clinical reviews when warranted; however, we found leadership only sporadically identified their staffs' opportunities for improvement. Taking all things into consideration, the OIG rated this indicator ***adequate.***

Case Review Results

Table 9. Case Review Emergency Services Results

Urgent or Emergent Events*	Deficiencies†	Significant Deficiencies‡
16	23	3

* Urgent or emergent events occurred in cases 1-6, 15, and 27-29.

† Deficiencies occurred in cases 1-6, 11, 27, and 28.

‡ Significant deficiencies occurred in cases 11 and 28.

Performed Well

OIG clinicians found WSP performed well in the following:

- CPR Quality[25]

  The OIG clinicians reviewed two cases in which CPR was performed and found nurses promptly initiated CPR and followed the basic life support process.[26]

Performed Satisfactorily, with Opportunities for Improvement

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

- Emergency Medical Response

  The OIG clinicians reviewed 12 emergency medical response events and found nurses responded promptly and usually implemented appropriate actions. However; on a few occasions, the first medical responders did not provide a sufficient assessment or implement an appropriate intervention. The following are examples:

  - In case 4, nurses responded to a medical alarm for this patient who had facial bleeding due to trauma and was confused; however, the nurses did not immediately initiate 9-1-1. Instead, we identified a five-minute delay.

[25] A minor CPR deficiency occurred in case 6.

[26] In CPR, basic life support (BLS) refers to a set of emergency procedures that are performed to help sustain life in a person experiencing cardiac or respiratory arrest. The BLS sequence is important because it provides the first line of care for a person in a life-threatening emergency, and it can make the difference between life and death. The BLS sequence includes steps such as performing CPR, using an automated external defibrillator (AED), and providing rescue breathing to a person who is not sufficiently breathing or does not have a pulse. The timely and correct performance of these procedures can help to restore circulation and breathing and improve the person's chance of survival.

- In case 6, nurses responded to a medical alarm. The patient's oxygen saturation result was low, and the patient's heart rate was fast. Although a nurse-initiated oxygen via a nasal cannula, this method of oxygen delivery was insufficient.[27] Additionally, the nurse delayed reassessment of the patient's oxygen saturation result.

- Nursing Performance[28]

  WSP TTA nurses usually provided sufficient assessments and interventions; however, on a few occasions nurses showed opportunities for improvement. The following are examples:

  - In case 27, custody staff transported this patient to a community emergency room for worsening cellulitis; however, the nurse did not conduct a handoff with the receiving emergency room medical staff.

  - In case 28, a nurse assessed this patient for a complaint of abdominal pain and vomiting. The nurse did not perform complete subjective and objective assessments. The nurse did not inquire about the symptom's onset and frequency. Further, the nurse did not examine the patient's abdomen.

- Nursing Documentation

  We found WSP's nurses documented their contact with patients; however, on a few occasions, documentation was inconsistent. The following are examples:

  - In case 5, nurses documented the patient had no neurological symptoms and also documented the patient had neurological symptoms of headache, difficulty opening his eye, and facial numbness.

  - In case 6, a nurse responded to a medical alarm for an unresponsive patient. The nurse documented the patient was unresponsive and not moving; however, the nurse also documented the patient was alert and guarding his abdomen.

- Provider Performance

  WSP providers generally made accurate diagnoses, documented thoroughly, and made appropriate triage decisions for TTA patients. OIG clinicians identified five deficiencies, one of which was significant as follows:[29]

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

[28] Nursing performance deficiencies occurred in cases 2, 4–6, 27, and 28. Two significant deficiencies occurred in case 28.

[29] Four minor deficiencies occurred in cases 1, 3, 11, and 28. One significant deficiency occurred in case 11.

- In case 11, the provider evaluated a patient with uncontrolled diabetes who had right facial pain and swelling in the TTA. The provider concluded this was a skin cellulitis and began treatment for such; however, the provider did not consider other differential diagnoses. The patient had a documented history of periodontal disease and dental caries, but this was not discussed or addressed. The provider did not examine the patient's oral cavity to determine whether the symptoms could be dental-related, which would require a different antibiotic medication. This increased the patient's possibility of having a serious infection in the face, a high-risk area susceptible to infections.

- Emergency Medical Response Review Process[30]

  WSP usually conducted clinical reviews for higher-level-of-care transfers, and deaths. However, OIG clinicians found WSP's medical leadership only sporadically identified their staffs' opportunities for improvement. The following are examples:

  - In case 2, a supervising registered nurse (SRN) II, the chief nurse executive (CNE), and the chief medical executive (CME) performed a clinical review for this patient, who was transferred to a higher level of care to rule out sepsis.[31] The reviewers did not identify that nursing staff documented vital signs were stable but did not document the actual vitals sign results. Additionally, the nurse did not assess the patient's inhaler use and did not ask whether the patient had his inhaler on his person.

  - In case 5, an SRN II, the CNE, and the CME performed a clinical review for this patient, who was transferred to a higher level of care to rule out an intracranial abnormality.[32] The reviewers did not identify the delay in contacting EMS for the patient after he presented with unequal pupils; elevated blood pressure; and neurological symptoms including headache, facial and arm numbness, and nausea.

Performed Poorly, Improvement Needed

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

[30] Emergency Medical Response Review Process deficiencies occurred in cases 1–6 and 27. No significant deficiencies occurred.

[31] Sepsis is an infection in the blood that can cause body organs to fail.

[32] Intracranial abnormality is something unusual or abnormal found inside the skull or brain.

Clinician On-Site Inspection

During the on-site inspection, the OIG clinicians interviewed the TTA nursing staff and supervisor. The TTA staff consists of two RNs for each shift. The TTA had three exam rooms, but staff indicated they utilized only two of the rooms. The nurses shared, when a medical emergency alarm is activated, the clinic LVNs and RN are the first responders. The TTA RNs monitor institutional radio traffic and will respond when they are needed. During the evening and night shifts, the TTA RN responds to all emergency medical alarms.

The TTA supervisor informed the OIG clinician, when patients transferred to a higher level of care, the SRN working during that shift completed the initial clinical review checklist. The SRN then routed the clinical review checklist through Docusign to the CNE, CME, and emergency response coordinator. When the SRN, CNE, or CME identify opportunities for improvement, an SRN must complete the training and submit the completed training to the emergency medical response review committee (EMRRC).

Photo 1. TTA.
Photographed 5-19-2026.

Case Review Recommendations

- Nursing and physician leadership should develop strategies to ensure the Emergency Medical Response Review Committee (EMRRC) thoroughly audits emergency events, identifies all deficiencies, and provides staff training in a timely manner. Leadership should implement and monitor remedial measures as appropriate.

- Nursing leadership should develop strategies, such as resuming random audits, to ensure nursing assessments, interventions, and documentation is complete and thorough. Leadership should implement and monitor remedial measures as appropriate.

Emergency Services: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(31.3%)

WSP performed poorly in 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

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

- WSP 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%).

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

- The Emergency Medical Response Review Committee (EMRRC) reviewed cases in a timely manner and ensured incident packages included all required documents for nine of 12 sampled patients (MIT 3.001, 75.0%). For three patients, the institution did not review the cases timely.

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

- Nursing staff inspected and inventoried emergency medical response bags (EMRBs) and ensured they contained all essential items for only one of the eight applicable clinical areas (MIT 3.101, 12.5%). For seven EMRBs, we found one or more of the following deficiencies: staff failed to ensure EMRB compartments were sealed and intact; staff had not inventoried the EMRBs when the seal tags were replaced; and staff failed to document oxygen tank level when seal tags were changed (see Photo 2, right).

Photo 2. Incomplete EMRB checklist log. Photographed 4-7-2026.

- Nursing staff failed to inspect and inventory treatment carts within the required time frames in both 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 3, right); and the treatment cart supplies inventory report lacked complete documentation of full inventory. Specifically, staff failed to record the actual quantities of medical supplies, resulting in an incomplete account of available stock.

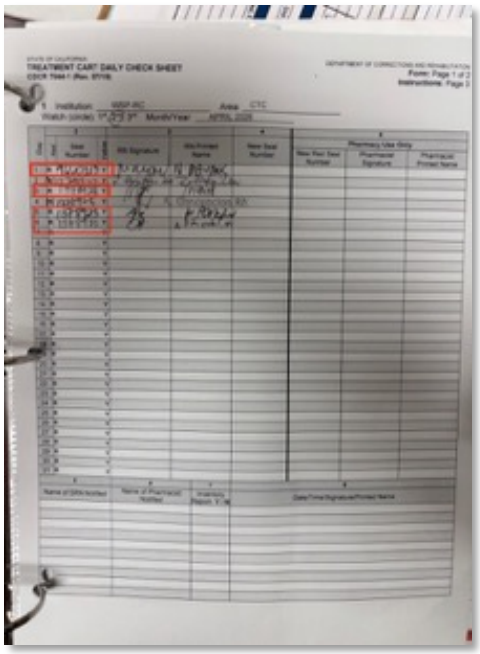


Photo 3. Incomplete treatment cart seal security check log documentation. Photographed 4-6-2026.

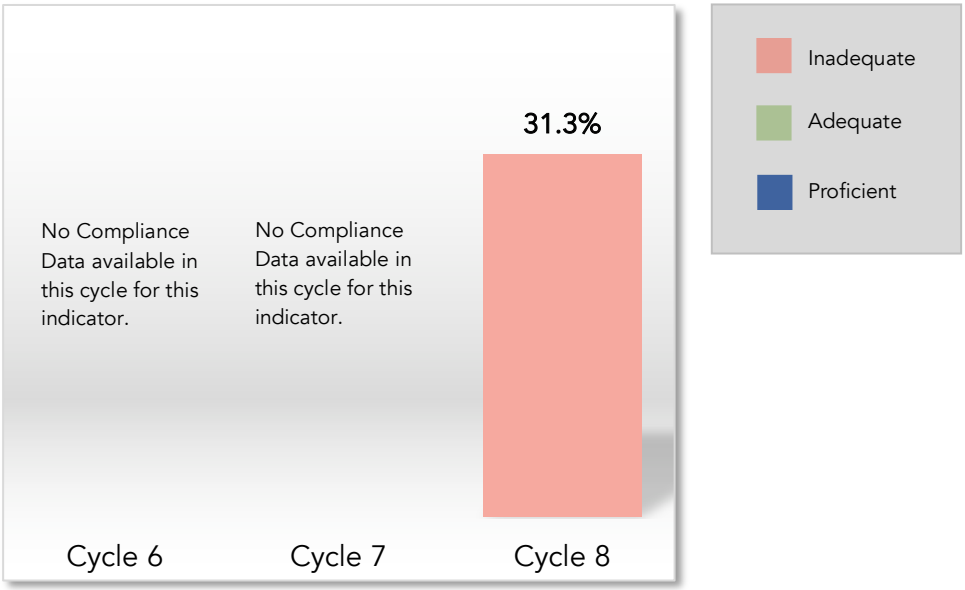
- Nursing staff did not properly inspect and inventory disaster response bags within the required time frames for applicable clinical areas (MIT 3.103, zero). During the on-site inspection, inspectors found the disaster bags lacked seal tags (see Photo 4, below left).

Photo 4. Disaster response bags lacked seal tags. Photographed 4-6-2026.

- The institution failed to conduct medical emergency response drills during each watch of the most recent quarter (MIT 3.104, zero). Three of the submitted packets lacked required documentation for the emergency drills performed.

Analysis of Performance Across Inspection Cycles

Figure 3. Emergency Services, Compliance Scores Across Cycles



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

The institution performed below established standards for emergency response and coordination, highlighting a significant need for improvement in this indicator. Specifically, the institution did not meet the 75.0 percent passing compliance threshold for emergency readiness and performance evaluation, reaching only 31.3 percent in Cycle 8.

Notably, while we conducted these individual emergency compliance tests in prior cycles, we relocated these tests in Cycle 8 to this new indicator. Thus, no prior cycle data is available for indicator comparison. However, we include below the cycle comparisons for each individual test, which indicates continuing excellent scores in MIT 3.105, significant improvement in MIT 3.001, and significant regression in MITs 3.101, 3.102, and 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	17.0%	0.0%	75.0%
MIT 3.101 & 3.102	78.0%	22.2%	MIT 3.101 12.5% MIT 3.102 0.0%
MIT 3.104	100%	66.7%	0.0%
MIT 3.105	100%	100%	100%

Note: 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.

Compliance Score Results

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)	9	3	0	75.0%
Clinical areas: Are emergency medical response bags inspected and inventoried within required timeframes, and do they contain essential items? (3.101)	1	7	3	12.5%
Clinical areas: Are treatment carts inspected and inventoried within required timeframes? (3.102)	0	2	9	0
Clinical areas: Are disaster response bags inspected and inventoried within required timeframes? (3.103)	0	1	10	0
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): **31.3%**				

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

Compliance Recommendations

- Nursing leadership should develop, implement, and monitor strategies to ensure nursing supervisors timely review emergency medical response incidents and thoroughly complete required documentation for 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, case review found WSP managed health information satisfactorily, significantly improving from Cycle 7. Staff timely retrieved, scanned, and reviewed hospital discharge records, specialty reports, and urgent and emergent records. However, while we found providers endorsed results timely, they often sent incomplete patient notification letters or did not send the letters at all. After considering all aspects, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 12. Case Review HIM Results

Events*	Deficiencies†	Significant Deficiencies‡
555	39	2

* The OIG reviewed 555 events.

† Deficiencies occurred in cases 2, 3, 7, 8, 10–14, 16, 27, 28, 30, and 32.

‡ Significant deficiencies occurred in cases 3 and 11.

Performed Well

OIG clinicians found WSP performed well in the following areas:

- Hospital Reports[33]
- Specialty Reports[34]
- Urgent and Emergent Records[35]
- Scanning Performance[36]

Performed Satisfactorily, with Opportunities for Improvement

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

Performed Poorly, Improvement Needed

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

- Diagnostic Reports

  Although WSP providers usually reviewed and endorsed test results timely, they needed improvement with the patient test result notification letters. We identified 29 deficiencies, 20 of which related to incomplete letters and nine to missing letters.[37] The following is an example:

  - In case 10, the patient received an x-ray for his right ankle, but the provider did not send the patient a test result notification letter explaining the x-ray results.

  We also discuss management of diagnostic reports in the **Diagnostic Services** indicator.

[33] One significant deficiency occurred in case 3.

[34] Three minor deficiencies occurred in cases 16, 28, and 32. One significant deficiency occurred in case 11.

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

[36] Five minor deficiencies occurred in cases 2, 11, 27, 28, and 32.

[37] Twenty minor deficiencies relating to incomplete patient notification letters occurred in cases 2, 7, 8, 10, 12–14, and 30, and nine minor deficiencies relating to missing patient notification letters occurred in cases 2, 10, and 30.

Clinician On-Site Inspection

OIG clinicians spoke with the health information management (HIM) supervisor. The supervisor reported expecting the impending loss of one limited term office assistant position, related to budgetary reasons, to affect staffing because the HIM staff would have only two remaining positions at that point. The supervisor stated the HIM staff was trying their best with the resources they had. The supervisor mentioned, although they had no backlogs with document scanning, one local hospital appeared to experience difficulty in timely sending their records to WSP.

Case Review Recommendations

The OIG offers no Case Review recommendations for this indicator.

HIM: Compliance Ratings and Results Summary

Compliance Rating
PROFICIENT
Compliance Score
(92.7%)

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

Compliance Testing Results

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

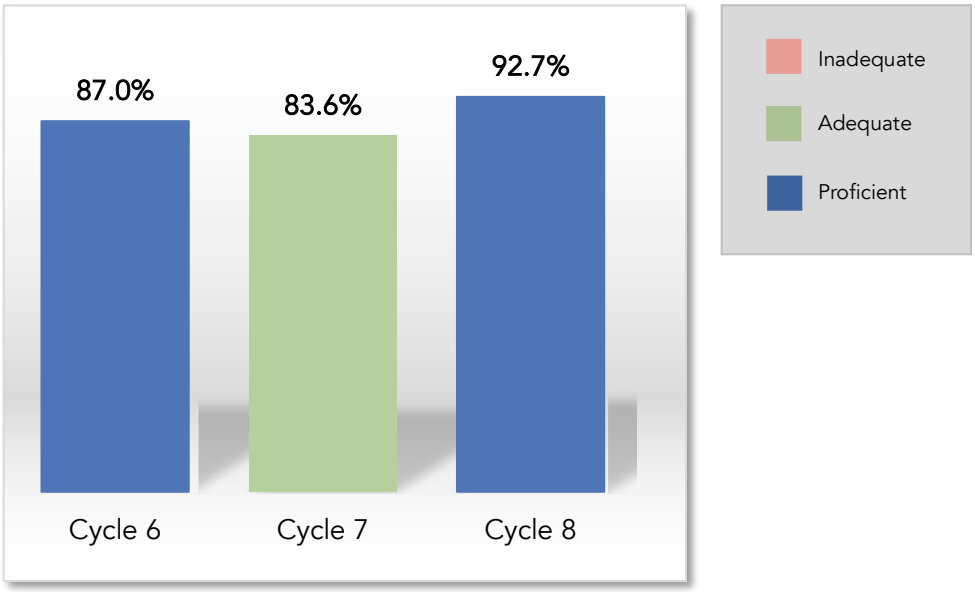
- The institution achieved a perfect compliance score for timely integrating health care services request forms (CDCR Forms 7362) into the electronic health record system (EHRS). Staff scanned all documented forms within the required time frames, ensuring immediate data availability for the patient care team (MIT 4.001, 100%).
- The institution demonstrated exceptional operational performance ensuring community hospital discharge documents were scanned into the patients' EHRS within required time frames for all 15 sampled patients (MIT 4.003, 100%).
- The institution labeled and scanned records into the patients' EHRS for all 25 patients (MIT 4.004, 100%).
- The institution exhibited proficiency ensuring the provider reviewed and endorsed community hospital discharge reports within five calendar days of discharge for all 15 sampled patients (MIT 4.005, 100%).

WSP 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 19 of 30 applicable sampled patients (MIT 4.002, 63.3%). For 11 patients, staff scanned the specialty reports between one and 12 days late.

Analysis of Performance Across Inspection Cycles

Figure 4. Health Information Management, Compliance Scores Across Cycles



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

In Cycle 8, WSP's performance exceeded the 75.0 percent compliance threshold for health information management, reaching 92.7 percent in Cycle 8. This score follows a ***proficient*** performance result of 87.0 percent in Cycle 6 and a lower ***adequate*** performance result of 83.6 percent in Cycle 7. The current score represents a significant improvement from the regressed performance in Cycle 7, indicating the institution's successful commitment to resuming strong performance in this indicator.

Compliance Score Results

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)	19	11	15	63.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	15	0	0	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	25	0	0	100%
For patients discharged from a community hospital: Did a provider review and endorse the report within five calendar days of discharge? (4.005)	15	0	0	100%
Overall percentage (MIT 4): **92.7%**				

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

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

Health Care Environment: Compliance Ratings and Results Summary

Compliance Rating
ADEQUATE
Compliance Score
(83.7%)

WSP delivered a strong performance in this indicator. Based on the overall compliance score, the OIG rated this indicator ***adequate***.

Compliance Testing Results

WSP 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 applicable clinical health care areas (MIT 5.101.2, 90.0%). In one location, the cabinet in the clinical area was found unclean; (see photo 5, right).

Photo 5. Unclean supply cabinet. Photographed 4-6-2026.

- The institution demonstrated excellent performance in ensuring staff consistently updated the corresponding cleaning logs for all 11 clinics (MIT 5.101.3, 100%).

- The institution attained perfect performance in ensuring clinical health care areas controlled exposure to blood-borne pathogens and contaminated waste for all 11 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 11 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 11 clinics (MIT 5.110.1, 100% and MIT 5.110.2, 100%). Furthermore, all 11 clinic exam rooms were equipped with working computer stations, well-maintained furniture, and accessible medical equipment (MIT 5.110.3, 100%).

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

- The institution ensured reusable non-invasive medical equipment was properly disinfected as warranted for five of six applicable clinical health care areas (MIT 5.102.2, 83.3%). For one clinic, the health care staff failed to remove exam table paper after conducting a patient encounter.

- Nine of 11 clinics ensured clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies (MIT 5.103, 81.8%). In two clinics, the patient restrooms lacked antiseptic soap and disposable towels.

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

- Five of nine medical staff observed adhered to universal hand hygiene precaution, in which staff follows proper handwashing protocols (MIT 5.104, 55.6%). In four clinics, clinicians did not wash or sanitize their hands before and after physically touching the patient.

- Five of 11 clinics ensured adequate management and storage of bulk medical supplies (MIT 5.107, 45.5%). Specific deficiencies for six clinics included disorganized medical supplies, medical supplies not accurately labeled for easy identification, improper co-storage of long-term food in the clinic area (see Photo 6, below left), improper co-storage of medical supplies and medications, storage of supplies beyond manufacture's guidelines (see Photos 7 and 8, below), and medical supplies stored directly on the floor.

Photo 6. Improper co-storage of long-term food. Photographed on 4-7-2026.

Photo 7. Expired medical supplies. Photographed on 4-7-2026.

Photo 8. Expired medical supplies. Photographed on 4-7-2026.

- Only three of 11 clinics ensured common areas and exam rooms were equipped with essential core medical equipment and supplies (MIT 5.108.2, 27.3%). In eight clinics, we found one or more of the following deficiencies: staff did not consistently conduct daily performance checks of the automated external defibrillator (AED); defibrillator test performance was found incomplete; oto-ophthalmoscope was non-functional; several clinics were missing peak flow meter and disposable tips, lubricating jelly, exam table disposable paper, and nebulization unit; and a glucometer quality control log was incomplete.

- Eight of 11 clinics ensured exam rooms allowed for privacy and confidentiality when providing medical services (MIT 5.110.4, 72.7%). In three clinics, the confidential medical records were kept visible, unsecured, and easily accessible to unauthorized persons (see Photo 9, right).

Photo 9. Confidential records visible and easily accessible in black bin. Photographed 4-7-2026.

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

- Cleaning staff is managed by California Correctional Training and Rehabilitation Authority (CALCTRA) formerly known as California Prison Industry

Authority (CALPIA), and WSP clinical staff did not express concerns with maintaining 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 (MIT 5.108.1, N/A).

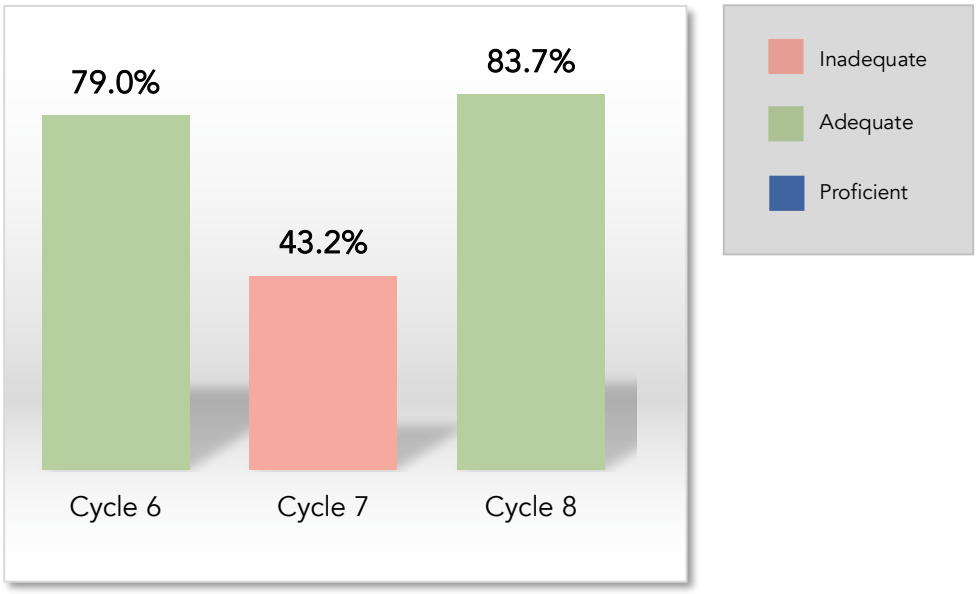
- We inspected indoor patient waiting areas. Health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 10, right). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas (MIT 5.109.2, N/A).

Photo 10. Sufficient patient waiting area. Photographed 4-7-2026.

- We deemed the compliance test for MIT 5.102.1 in this indicator not applicable during this 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 WSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, WSP performed above established standards for health care environment, successfully exceeding the requirements for this cycle. The institution met the 75.0 percent passing compliance threshold for health care environment, reaching an ***adequate*** score of 83.7 percent in Cycle 8. This rating demonstrates a substantial recovery following an ***adequate*** rating of 79.0 percent in Cycle 6 and subsequent regression to an ***inadequate*** rating of 43.2 percent in Cycle 7, indicating a successful return to established benchmarks in this area.

Compliance Score Results

Table 14. Health Care Environment Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For informational purposes only: Did the clinical health care staff report any concerns with maintaining infection control? (5.101.1)	0	0	11	N/A
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101.2)	9	1	1	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)	11	0	0	100%
Infection control: Do clinical health care areas ensure that reusable invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.1)	0	0	11	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)	5	1	5	83.3%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	9	2	0	81.8%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	5	4	2	55.6%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	11	0	0	100%
Warehouse, Conex, and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	5	6	0	45.5%
For informational purposes only: Did clinical health care staff report concerns with access to all vital and properly working medical equipment and sufficient medical supplies? (5.108.1)	0	0	11	N/A
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108.2)	3	8	0	27.3%
Clinical areas: Are the environments in the common clinical areas conducive to providing medical services? (5.109.1)	11	0	0	100%
Clinical areas: Are the environments in the common non-clinical areas conducive to providing medical services? (5.109.2)	11	0	0	100%
Clinical areas: Do the clinic exam rooms have adequate space to provide medical services? (5.110.1)	11	0	0	100%
Clinical areas: Are the clinic exam rooms free of clutter and conducive to providing medical services? (5.110.2)	11	0	0	100%
Clinical areas: Do clinic exam rooms have working computer stations and well-maintained furniture and accessible medical equipment? (5.110.3)	11	0	0	100%
Clinical areas: Do clinic exam rooms allow for privacy and confidentiality when providing medical services? (5.110.4)	8	3	0	72.7%
For informational purposes only: Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This test is not scored. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **83.7%**

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 Ratings and Results Summary

In this cycle, case review found WSP performed satisfactorily in the transfer process. For patients transferring into the institution, WSP nurses performed initial nursing assessments, ensured medication continuity, and scheduled nurse and provider follow- up appointments as required. For patients transferring out of the institution, nurses occasionally did not complete thorough assessments and often did not communicate pending specialty appointments to the receiving institutions. For patients returning from the hospital, the receiving nurses did not always perform thorough assessments, and the nurses and providers did not always provide continuity of hospital-recommended medications. 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‡
37	13	5

* The OIG clinicians reviewed 37 events in 19 cases in which patients transferred into or out of the institution and seven events in which patient's returned from an off-site hospital or emergency room.

† Deficiencies occurred in cases 1–4, 6, 11, 19, 21, 22, 27, 30, and 32.

‡ Significant deficiencies occurred in cases 2–4, 6, and 11.

Performed Well

OIG clinicians found WSP performed well in the following:

- Transfers In[38]

Performed Satisfactorily with Opportunities for Improvement

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

- Transfers Out[39]

  OIG clinicians found nurses generally screened patients appropriately and ensured transfer out requirements were met. Nurses provided medications to patients and most patients transferred with their medications. However, nurses often did not communicate pending specialty appointments to the receiving institutions. The following deficiencies showed room for improvement:

  - In case 21, the nurse did not accurately complete the interfacility documentation to communicate a pending specialist HIV consult to the receiving institution.
  - In case 32, the nurse did not document whether the patient transferred with a five-day supply of prescribed medication.

[38] OIG clinicians reviewed eight transfer-in events in cases 6 and 18–20. Transfer-in deficiencies occurred in cases 6 and 19. No significant deficiencies occurred.

[39] OIG clinicians reviewed 16 transfer-out events in cases 1, 2, 21–23, 27, 28, 30, and 32. Transfer-out deficiencies occurred in cases 21, 22, 30, and 32. No significant deficiencies occurred.

- In case 30, the nurse did not ensure the patient had all his ordered durable medical equipment. As a result, the patient did not transfer with his back brace and walker. In addition, the nurse did not notify the receiving facility of the patients' pending specialty appointments with both an infectious disease specialist and a neurologist for continued joint management of the patient's osteomyelitis and epidural abscess.[40]

- Hospital Returns[41]

  OIG clinicians identified opportunities for improvement in conducting thorough nursing assessments, providing interventions, and ensuring complete documentation. At times, WSP health care staff did not address hospital recommendations and did not maintain medication continuity. We identified seven hospital return deficiencies, five of which were significant. Examples are seen in the following cases:

  - In case 2, the nurse assessed the patient after returning from a hospital admission with diagnosis of community-acquired pneumonia and acute respiratory failure. The nurse documented the patient had a decreased oxygen level and diminished breath sounds throughout the lung fields. However, the nurse did not notify the provider of abnormal findings. In addition, the nurse did not ensure the patient had his rescue inhaler on person prior to discharge to his housing unit.

  - In case 4, the provider ordered newly recommended medications for the patient, who returned from a hospitalization with a diagnosis of heart failure and facial trauma due to an episode of syncope.[42] However, newly prescribed medications were either issued late, or doses were missed. These included critical heart condition medications.

Performed Poorly, Improvement Needed

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

[40] Osteomyelitis is an infection of the bone. An epidural abscess, which requires immediate treatment, is a dangerous pocket of pus and germs that forms in the space surrounding the brain and spinal cord.

[41] Hospital-return deficiencies occurred in cases 1–4, 6, 11, and 27. Significant deficiencies occurred in cases 2–4, 6, and 11.

[42] Syncope is a transient loss of consciousness, which can be caused by insufficient blood flow to the brain.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians inspected the receiving and release (R&R) area and interviewed the nurses. The staffing consists of four providers, one transfer nurse, two RNs on first watch, three RNs on second watch, and three RNs on third watch. This team is responsible for completing the transfer packets and ensuring WSP meets transfer requirements for all patients who transfer out of the institution, conducting intake screening for patients arriving from the county jail or other facilities, and maintaining medication and care continuity for all patients coming through the R&R area.

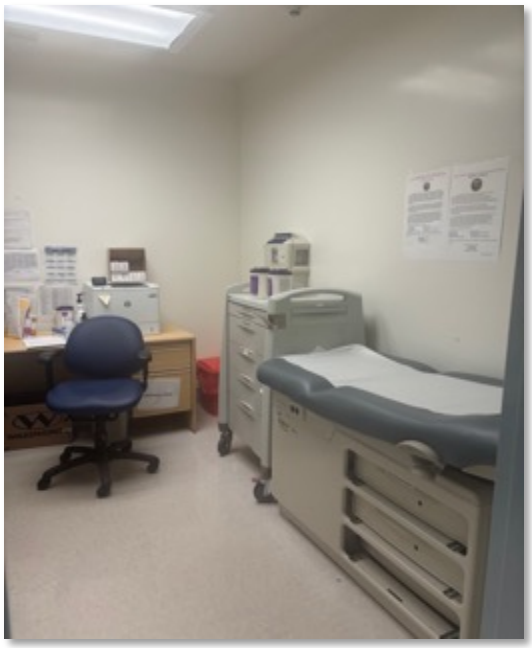


Photo 11. Receiving and Release RN exam room. Photographed 5-20-2026.

WSP reported receiving an average of 373 patients who transfer in each week, which includes all transfer in and reception center patients, as well as handling approximately 300 patients who transfer out. The nurses were knowledgeable about the transfer process and the process for patients returning from hospitalization. The R&R nursing staff provided positive feedback regarding their support from nursing leadership.

Please see **Reception Center** Arrivals indicator for additional information.

Case Review Recommendations

- Medical and nursing leadership should develop strategies to ensure nursing staff reconcile, order, and timely administer hospital discharge medications without interruption as well as timely administer transfer-out medications without interruption. Leadership should implement and monitor remedial measures as appropriate.

- Nursing leadership should develop strategies to ensure nursing staff thoroughly complete the transfer-out screening process, and nurses perform complete focused assessments on patients returning from the community hospital. Leadership should implement and monitor remedial measures as appropriate.

Transfers: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(68.7%)

WSP's performance needs improvement for this indicator. Based on the overall compliance score result of 68.7 percent, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

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

- Nursing staff showed sufficient performance in completing the assessment and disposition sections of the initial health screening form for 19 of 24 applicable sampled patients (MIT 6.002, 79.2%). For five patients, the registered nurse (RN) did not thoroughly complete the assessment and disposition of the initial health screening forms.

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

- Nursing staff completed initial health screenings and answered all screening questions within the required time frame for 17 of 25 sampled patients (MIT 6.001, 68.0%). For eight patients, nursing staff failed to document a complete set of vitals and weight measurements during screening process.

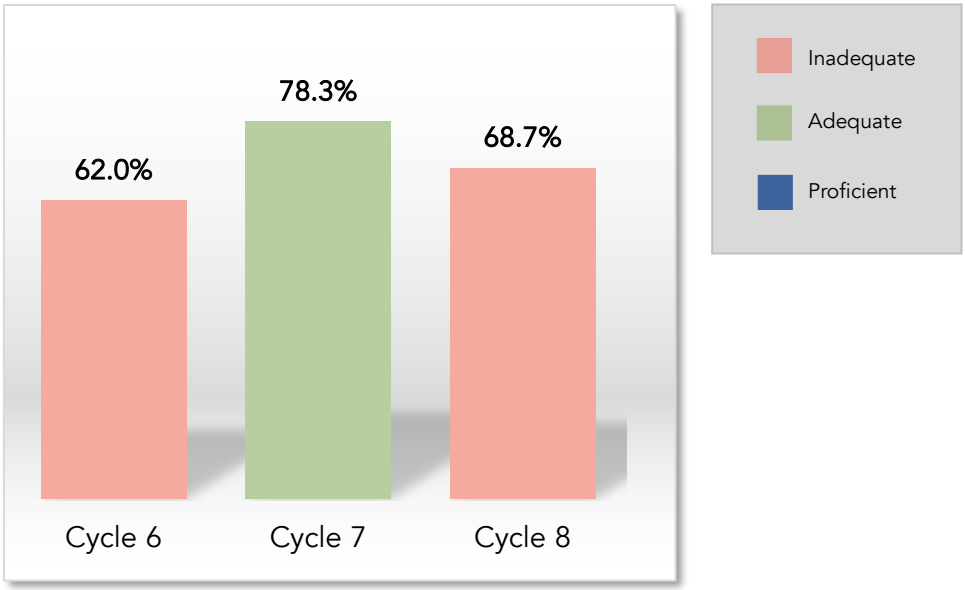
- Nursing staff ensured medications were administered or delivered without interruption for only five of 18 applicable sampled patients (MIT 6.003, 27.8%). For 13 patients, we found one or more of the following deficiencies: incomplete documentation of the patient's stated reason for refusing medication; incomplete documentation of the patient's stated reason for not presenting to the medication line; or the record contained no evidence of patient receiving or refusing ordered medication during our review period.

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 WSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, WSP performed below established standards for **Transfers**, failing to meet the requirements for this cycle. The institution fell short of the 75.0 percent passing compliance threshold for this indicator, reaching an ***inadequate*** score of only 68.7 percent in Cycle 8. This score follows a previous ***inadequate*** performance result of 62.0 percent in Cycle 6 and a subsequent improved performance to an ***adequate*** score of 78.3 percent in Cycle 7. The current Cycle 8 score is a regression into the ***inadequate*** range, indicating the institution's performance has slipped back below the minimum established standards for this indicator.

Compliance Score Results

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)	17	8	0	68.0%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	19	5	1	79.2%
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)	5	13	7	27.8%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	10	0	0	100%
Overall percentage (MIT 6): **68.7%**				

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

Compliance Recommendations

- Nursing leadership should develop strategies to ensure nurses administer medications without interruption to newly arrived patients. Leadership should implement and monitor remedial measures as appropriate.
- The department should develop strategies, such as an electronic alert, to ensure receiving and release (R&R) nurses properly and thoroughly complete initial health screening questions and follow up as needed. The department 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 WSP overall performance in medication management was sufficient. Our clinicians found the institution performed well in medication continuity for patients who transfer in and out of the institution, patients arriving in through the reception center, and in specialized medical housing. However, we found opportunities for improvement in medication continuity for patients on chronic care medication, for patients discharged from a hospitalization, and newly prescribed medications. 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‡
112	20	10

* The OIG clinicians reviewed 112 events in 30 cases related to medications.

† Deficiencies occurred in cases 1, 2, 4, 11, 12, 14, 15, 17, 19, 28, and 29.

‡ Significant deficiencies occurred in cases 2, 4, 11, 12, 15, and 29.

Performed Well

OIG clinicians found WSP performed well in the following:

- Transfer Medications[43]
- Reception Center Medications[44]
- Specialized Medical Housing Medications[45]

Performed Satisfactorily with Opportunities for Improvement

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

- Hospital Discharge Medication[46]

  OIG clinicians found most patients received their medications in a timely manner after hospital discharge. However, the following is an opportunity for improvement.

  - In case 4, the CTC patient returned from a hospitalization after he was admitted for loss of consciousness due to a cardiac condition. The provider ordered newly prescribed cardiac medication as well as a previously ordered blood thinner medication. However, the patient did not receive the morning dose of two of the medications and received two other medications one day late.

- Chronic Medication Continuity[47]

  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 12, for the month of September, the patient did not receive his two diabetic medications and one cholesterol medication. In October, the patient received one diabetic medication nine days late and received the cholesterol medication and the second diabetic medication 17 days late.

  - In case 29, the licensed vocational nurse (LVN) documented the patient refused his blood pressure medication and noted the patient's heart rate was abnormally

[43] We identified no transfer-out medication deficiencies. One transfer-in medication deficiency occurred in case 19. No significant deficiencies occurred.

[44] Reception Center medication deficiencies occurred in cases 2 and 28. No significant deficiencies occurred.

[45] One specialized medical housing medication deficiency occurred in case 29. No significant deficiencies occurred.

[46] One significant hospital discharge medication deficiency occurred in case 4.

[47] Chronic care medication deficiencies occurred in cases 2, 11, and 14. Significant deficiencies occurred in case 2 and 11.

low. However, the LVN did not notify the registered nurse (RN) or the provider of the abnormally low heart rate. Additionally, the LVN did not reassess the patient's heart rate.

- In case 6, we identified documentation discrepancies. The nurse documented patient refused medications three times during the morning medication pass and once at the noon medication pass. However, at 2:12 p.m. the same day, the patient was found deceased in the cell with rigor mortis, which sets in hours after death.[48]

- Newly Prescribed Medication.[49]

  The institution performed satisfactorily with ensuring availability, administration, and delivery of newly prescribed medication within the required time frame. The following are examples:

  - In case 11, the diabetic patient was scheduled to receive an antibiotic prescribed for a skin infection; however, the patient missed the first two doses.

  - In case 15, the patient was prescribed an antibiotic for an infection on his left arm. The patient received the antibiotic one day late.

Performed Poorly, Improvement Needed

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

[48] Rigor mortis is the natural stiffening of the body's muscles that occurs a few hours after death.

[49] Newly prescribed medication deficiencies occurred in cases 11, 14, and 15. Significant deficiencies occurred in cases 11 and 15.

Clinician On-Site Inspection

Photo 12. D yard Medication Distribution Room (MDR). Photographed 5-20-2026.

During the on-site inspection, OIG clinicians interviewed the medication administration nurses in A and D yard. The staff shared A yard contains approximately 1,000 patients. A yard is staffed with two LVNs on each shift with one medication area which serves all of A yard patients. D yard is a reception center yard and has two medication areas. Each medication area serves three buildings. They are staffed with one LVN each shift and will utilize a second LVN as needed. Additionally, building D6 is the restricted housing unit where two psychiatric technicians specifically administer medications.

The staff shared they attend daily huddles where they report any medication concerns. The staff were knowledgeable about the keep on person (KOP) medication administration process.[50] The staff reported, when patients fail to pick up their KOP medications after four days, the staff will go out to the prospective building and have the patient sign a refusal. Additionally, they will communicate with the RN and have the patient scheduled for patient education or a provider evaluation. They also reported all KOP medications are returned to pharmacy after the fourth day. The staff in both medication areas expressed satisfaction in their roles, and shared they felt supported by nursing leadership.

Case Review Recommendations

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

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

Medication Management: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(70.7%)

WSP's performance showed opportunities for improvement in this indicator. Based on the overall compliance score result of 70.7 percent, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

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

- The provider ordered post-hospitalization medication orders within the required time frames for 14 of 15 sampled patients (MIT 7.003.1, 93.3%). For one patient, the medications were not ordered within eight hours of the patient's return from the hospital.
- The provider ordered new medications for patients arriving from a county jail within the required time frames for nine of 10 applicable sampled patients (MIT 7.004.1, 90.0%). For one patient, the record contained no evidence the provider documented justification for not ordering medications upon the patient's arrival at the reception center.
- The institution's pharmacy made available new medication orders for patients arriving from a county jail within the required time frame for all four applicable sampled patients (MIT 7.004.2, 100%).
- The institution adequately stored and secured narcotic medications for all eight applicable clinic and medication line locations (MIT 7.101, 100%).
- Staff successfully stored valid, unexpired medications in eight of nine applicable medication line locations (MIT 7.104, 88.9%). For one location, nursing staff did not label multi-use dose medication as required by policy.
- Staff in all six applicable medication preparation and administration areas showed appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 100%).

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

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

- The institution showed proficiency in making new order prescription medications available to patients within the required time frames for 10 of 12 applicable sampled patients (MIT 7.002.1, 83.3%). For two patients, the pharmacy did not make newly ordered medications available to the patient within the required time frame.

- The institution administered or issued new order prescription medications within required time frames for 21 of 25 sampled patients (MIT 7.002.2, 84.0%). In four patients, we found one or more of the following deficiencies: nursing staff failed to deliver medication to the patient by the ordering provider's administration date, or staff did not document the patient's stated reason for refusing medication or reason for not presenting to the medication line.

- We examined 10 medication error reports. The PIC timely and correctly processed for eight reports (MIT 7.112, 80.0%). For two reports, we found one or more of the following deficiencies: the medication error follow-up form was completed incorrectly because the initiation date of the form preceded the actual reported date of the incident, or the form was missing the name of the pharmacist completing the form.

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

- Only 13 of 22 applicable patient samples received chronic care medications within required time frames (MIT 7.001, 59.1%). In nine patients, we found one or more of the following deficiencies: chronic care medications were not made available to the patients in a timely manner; the record contained no evidence the patient either refused or received their chronic care medications; staff did not document the patient's stated reason for refusing medication; and "keep on person" (KOP) medications were not issued within policy time frames.

- The institution's pharmacy made available post-hospitalization medication orders within the required time frame for seven of 13 applicable sampled patients (MIT 7.003.2, 53.9%). For six patients, the pharmacy did not fill and dispense medications as ordered in a timely manner.

- The institution administered or issued post-hospitalization medication orders within the required time frames for seven of 15 applicable sampled patients (MIT 7.003.3, 46.7%). In eight patients, we found one or more of the following deficiencies: staff did not document the patient's stated reason for refusing medication or reason for not presenting to the medication line; nursing staff failed to deliver medication to the patient by the ordering provider's administration date; staff did not issue KOP medications within policy time frames; and the record contained no evidence showing whether the patient refused or received medication.

- The institution administered or issued new medication orders for patients arriving from a county jail within the required time frames for two of nine applicable sampled patients (MIT 7.004.3, 22.2%). In seven patients, we found one or more of the following deficiencies: staff did not document the patient's stated reason for refusing medication, and nursing staff failed to deliver medication to the patient by the ordering provider's administration date.

- The institution administered or delivered medications without interruption for patients transferring within the institution for 12 of 25 patients (MIT 7.005, 48.0%). For 13 patients, we found one or more of the following deficiencies: nursing staff failed to completely document the patient's stated reasons for refusing medication and reasons for not presenting to the medication line, or the record contained no evidence showing whether the patient refused or received the medication.

- The institution administered or delivered medications without interruption to patients laying over at WSP for five of seven applicable sampled patients (MIT 7.006, 71.4%). For two patients, nursing staff failed to completely document the patient's stated reason for refusing medications.

- WSP 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, right), or medication drawers were found unsanitary (see Photo 14, below left).

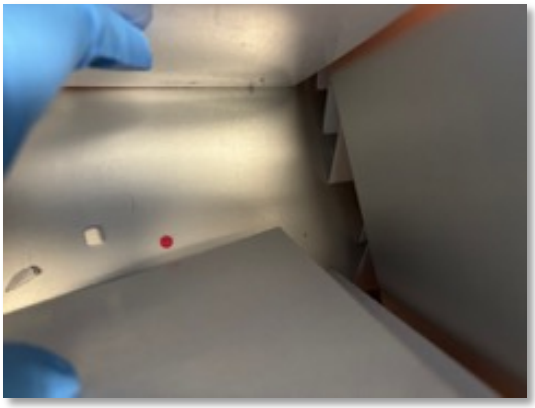


Photo 14. Nurses did not maintain unissued medication in its original labeled packing. Photographed 4-7-2026.

Photo 13. Medication drawer found unsanitary. Photographed 4-6-2026.

- Staff kept medications protected from physical, chemical, and temperature contamination in only three of nine applicable clinic and medication line locations (MIT 7.103, 33.3%). In six locations, we found one or more of the following deficiencies: medication refrigerators were unsanitary, or staff did not store oral and topical medications separately.

- Nurses exercised proper hand hygiene and contamination control protocols in four of six applicable locations (MIT 7.105, 66.7%). 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.

- Staff in only three of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 50.0%). In three 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.

- WSP did not properly stored nonrefrigerated medication in the pharmacy location (MIT 7.109, zero). Inspectors found staff storing personal items in the medication preparation area.

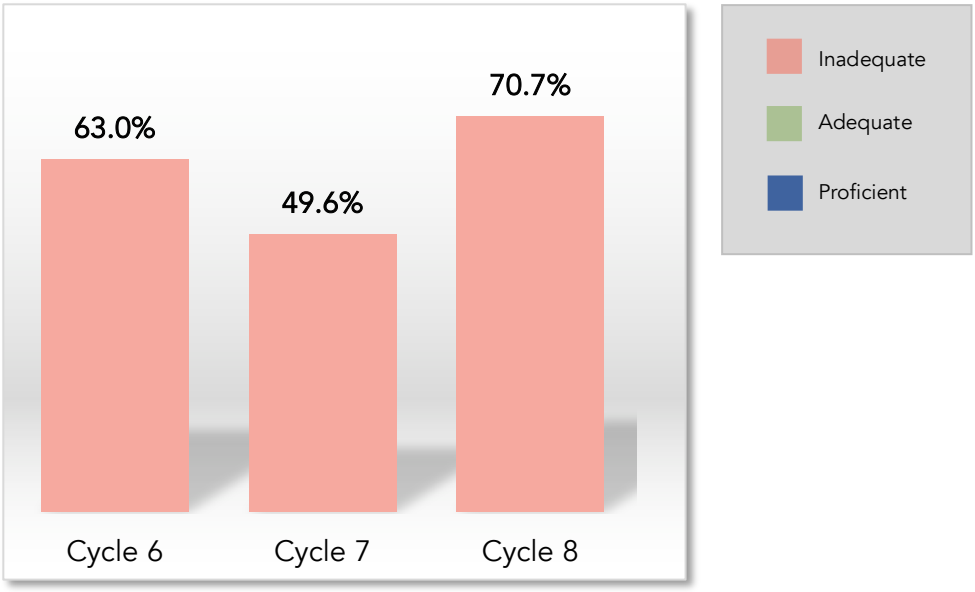
The following tests are not scored but are reported for informational purposes:

- 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 WSP, the OIG did not find any applicable medication errors (MIT 7.998, N/A).

- The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Two of the five applicable patients interviewed indicated they had access to their rescue medications. Three 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 WSP Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, WSP performed below established standards for medication management. The institution did not meet the 75.0 percent passing compliance threshold for this indicator, attaining an ***inadequate*** score of 70.7 percent in Cycle 8. However, this score represents a significant effort to improve from a previous ***inadequate*** performance result of 63.0 percent in Cycle 6 and a subsequent regression to a lower ***inadequate*** performance result of 49.6 percent in Cycle 7. While the overall performance in this indicator still remains below ***adequate*** levels, highlighting a continuing need for improvement, WSP has shown great progress since Cycle 7, achieving closer to an ***adequate*** level of performance.

Compliance Score Results

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)	13	9	3	59.1%
Did health care staff make available, new order prescription medications to the patient within the required time frames? (7.002.1)	10	2	13	83.3%
Did health care staff administer or issued new order prescription medications to the patient within the required time frames? (7.002.2)	21	4	0	84.0%
Upon the patient's discharge from a community hospital: Did the provider order the medications within required time frames? (7.003.1)	14	1	0	93.3%
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)	7	6	2	53.9%
Upon the patient's discharge from a community hospital: Were all ordered medications administer or issued to the patient within required time frames? (7.003.3)	7	8	0	46.7%
For patients received from a county jail: Did the provider order the medications within required time frames? (7.004.1)	9	1	10	90.0%
For patients received from a county jail: Were all medications made available to the patient within the required time frames? (7.004.2)	4	0	16	100%
For patients received from a county jail: Were all ordered medications administer or issued to the patient within required time frames? (7.004.3)	2	7	11	22.2%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	12	13	0	48.0%
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)	5	2	3	71.4%
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	0	3	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	5	4	2	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)	3	6	2	33.3%
All clinical and medication line storage areas for non-narcotic medications: Does the institution safely store non-narcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	1	2	88.9%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	4	2	5	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	0	5	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	3	3	5	50.0%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%

Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	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)	8	2	0	80.0%
For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This test is not scored. Please see the indicator for discussion of this test.			
For Information Purposes Only: Pharmacy: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This test is not scored. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **70.7%**

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. At the time of our inspection, the department designated WSP as a high risk institution for coccidioidomycosis. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Preventive Services: Compliance Rating and Results Summary

WSP performed very well in this indicator. Based on the overall compliance score, the OIG rated this indicator ***proficient***.

Compliance Testing Results

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

- The institution properly administered TB medications for 23 of 25 sampled patients (MIT 9.001, 92.0%). For two patients, nursing staff did not document the patient's stated reason for refusing the medication.
- The institution monitored patients taking TB medications during the treatment period for 21 of 24 applicable sampled patients (MIT 9.002, 87.5%). For two patients, we found no evidence of monthly monitoring completed within policy requirements. For the remaining patient, medical staff failed to document and address the required clinical symptoms and potential adverse drug reactions in the TB Screening Evaluation Report.
- The institution demonstrated proficiency in screening patients for TB for 24 of 25 sampled patients (MIT 9.003, 96.0%). For one patient, the record contained no evidence the patient received or refused the annual TB screening within the last 12 months.

- The institution demonstrated proficiency in offering influenza vaccinations during the most recently completed influenza season for 24 of 25 sampled patients (MIT 9.004, 96.0%). For one patient, the record contained no evidence staff completed a refusal form during our review period.

- The institution demonstrated proficiency in offering colorectal cancer screening to 22 of 25 patients (MIT 9.005, 88.0%). In three 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 or had a normal colonoscopy result.

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

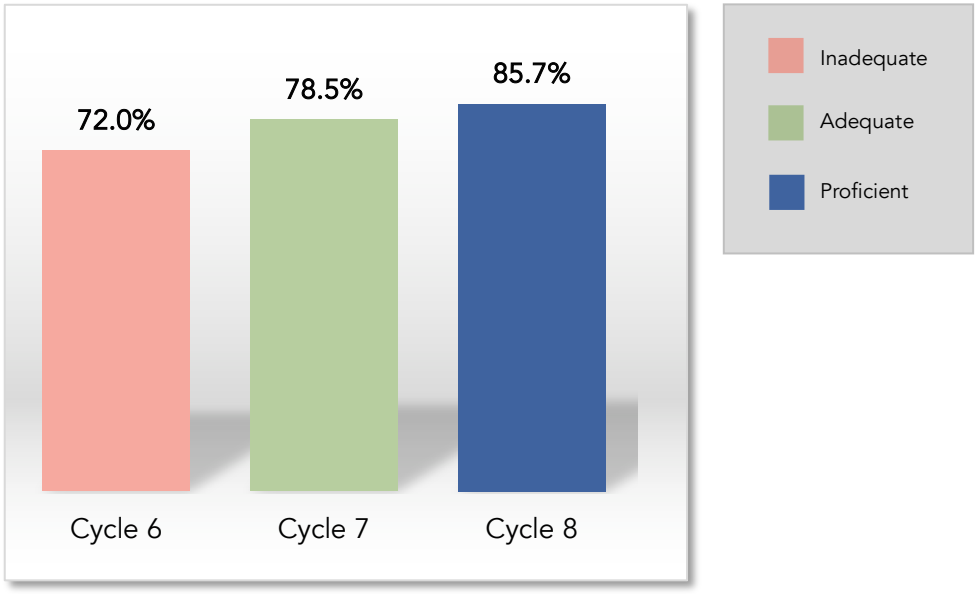
- The institution transferred out patients identified at the highest risk of contracting coccidioidomycosis (valley fever) infection for 19 of 25 patients (MIT 9.009, 76.0%). For six patients, they were transferred two and 26 days late from the required time frame.

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

- The institution offered immunizations to chronic care patients for 11 of 17 applicable sampled patients (MIT 9.008, 64.7%). For six patients, the record contained no evidence showing whether chronic care patients received or refused their pneumococcal vaccinations.

Analysis of Performance Across Inspection Cycles

Figure 8. Preventative Services, Compliance Scores Across Cycles



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

In Cycle 8, WSP 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 a ***proficient*** score of 85.7 percent in Cycle 8. This score follows a prior ***inadequate*** performance result of 72.0 percent in Cycle 6 and an improved ***adequate*** performance result of 78.5 percent in Cycle 7, indicating the institution has made a successful commitment to significantly improving in this indicator.

Compliance Score Results

Table 19. Preventive Services Compliance Test Scores

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	23	2	0	92.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent 90-day period they were on the medication? (9.002)	21	3	1	87.5%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	24	1	0	96.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	24	1	0	96.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	22	3	0	88.0%
Female patients from the age of 40 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	11	6	8	64.7%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	19	6	0	76.0%
			Overall percentage (MIT 9):	**85.7%**

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 causes for challenges to timely monitoring patients taking TB medications and should implement and monitor appropriate remedial measures.
- Health care leadership should determine the root causes for challenges to timely offering immunizations to chronic care patients and should implement and monitor appropriate remedial measures.

Nursing Performance

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

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

Nursing Performance: Case Review Ratings and Results Summary

WSP's overall nursing care was timely and appropriate. The nurses performed well in the reception center and transfer-in process. We found nurses performed satisfactorily with opportunities for improvement in the following areas: outpatient, wound care, emergency services, transfers-out, hospital returns, medication management, and specialty services. However, we found nursing performance needed improvement in specialized medical housing. Considering all factors, the OIG rated this indicator ***adequate.***

Case Review Results

Table 20. Case Review Nursing Performance Results

Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
134	61	11

* We reviewed 134 nursing encounters in 42 cases. Of the nursing encounters we reviewed, 63 were in the outpatient setting.

† Deficiencies occurred in cases 1, 2, 4–6, 13–15, 21, 22, 27–30, 32–34, 38, 40, 41, 43, 44, and 46–49.

‡ Significant deficiencies occurred in cases 2, 4, 6, 28–30, and 41.

Table 21. Case Review Outpatient Nursing Performance Results

Outpatient Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
63	30	3

* Nursing outpatient events occurred in cases 1–3, 13–15, 27–29, and 33–50. In the total number of nursing outpatient events, 44 were sick call events. Sick call events occurred in cases 1–3, 10, 13–15, 27, 29, and 33–50.

† Outpatient nursing deficiencies occurred in cases 1, 2, 13–15, 29, 33, 34, 38, 40, 41, 43, 44, and 46–49.

‡ Significant deficiencies occurred in cases 2 and 41.

Performed well

OIG clinicians found WSP nurses performed well in the following:

- Reception Center

  Nurses performed exceptionally well in assessments, interventions, and documentation for patients arriving to the reception center (RC). Please refer to the **Reception Center** indicator for further details.

- Transfers In

  Nurses performed well in initial assessments, ensured medication continuity, and scheduled nurse and provider follow-up appointments as required. Please refer to the **Transfers** indicator for further details.

Performed Satisfactorily with Opportunities for Improvement

- Outpatient Nursing Assessments, Interventions, and Documentation

  Our clinicians found WSP nurses mostly triaged sick calls appropriately and assessed the patients in a timely manner. Nurses generally performed appropriate assessments and interventions. However, we identified a pattern of incomplete assessments, failure to co-consult with the provider when warranted, and missing documentation. The following are examples:

  - In case 2, the nurse assessed the patient for a nasal spray replacement and complaints of pneumonia symptoms returning. The nurse documented the patient had a strong cough with sputum and abnormal lung sounds with bilateral wheezes. However, the nurse did not contact the provider to report the abnormal findings. Additionally, the nurse did not identify the patient was at risk for worsening infection due to diagnosis of HIV and recent hospitalization for pneumonia.[51]

  - In case 14, the RN assessed the patient after the medication LVN reported the patient had an elevated blood pressure during medication administration. The nurse messaged the provider to report the patient's uncontrolled blood pressure and non-adherence to medication. However, neither the LVN nor RN documented the patient's elevated blood pressure reading.

  - In case 41, the RN assessed the patient for complaints of fluctuation in heart rate, high blood pressure, headaches, left arm pain, stomach pain and heartburn. However, the nurse did not assess the onset and frequency of symptoms, assess range of motion, extremity strengths, tone and sensation to the left arm, and did not assess the specific area of stomach pain or perform a corresponding assessment. Additionally, the nurse did not co-consult with the provider or initiate a referral for fluctuation in heart rate. During the case review inspection, the institution agreed with the deficiency.

[51] HIV (human immunodeficiency virus) attacks the body's immune system, which is the body's system for fighting off infections and illnesses.

- Wound Care[52]

  Our clinicians reviewed three cases involving wound care and found nurses overall performed satisfactorily. However, the following examples showed opportunities for improvement:

  - In case 13, the nurse assessed the patient with a wound to the upper back area with abnormal drainage, redness, swelling, and discoloration and which felt warm and tender to touch. The nurse co-consulted with the provider and received orders for pain medication, an antibiotic, and a nurse follow-up in 10 days. However, the nurse did not perform wound care to the upper back wound area.

  - In case 15, during the months of October and November 2025, the clinic nurses performed wound care to the patient's right hand wound. However, the nurses did not always describe all aspects of the wound to include wound measurements or the color of the drainage.

- Emergency Services

  We found nurses performed well in providing CPR. They promptly responded to emergency alarms and usually provided sufficient assessments and interventions. Please refer to the **Emergency Services** indicator for further details.

- Transfers Out

  For patients transferring out of the institution, nurses occasionally did not complete thorough assessments and often did not communicate pending specialty appointments to the receiving institutions. Please refer to the **Transfers** indicator for further details.

- Hospital Returns

  For patients returning from the hospital, the receiving nurses did not always perform thorough assessments and did not always document the continuity of hospital-recommended medications or the co-consult details they provided to the provider. Please refer to the **Transfers** indicator for further details.

- Medication Management

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

[52] Wound care events occurred in cases 2, 13, and 15. Deficiencies occurred in each case. We identified no significant deficiencies.

- Specialty Services

  OIG clinicians reviewed two encounters for which patients returned to WSP after an off-site specialist appointment, and we identified only one significant deficiency. Please refer to the **Specialty Services** indicator for further details.

Performed Poorly, Improvement Needed

OIG clinicians found WSP nurses performed poorly in the following:

- Specialized Medical Housing

  OIG clinicians found CTC nurses promptly assessed patients and administered medications without a lapse in continuity. However, we found CTC nurses needed improvement in thorough admission assessments, daily assessments, and providing appropriate interventions. Please refer to the **Specialized Medical Housing** indicator for further details.

Not Applicable

- Care Coordination/Case Management

  OIG clinicians received no case samples that involved care coordination or case management events.

Clinician On-Site Inspection

During the on-site inspection, the OIG clinicians interviewed nursing staff and supervisors in A and D yard. We attended huddles for A yard, M yard, and D yard. The huddles were well organized and all required staff attended. The staff were familiar with the patient population and discussed various patient care concerns.

The staff on A yard reported they were recently under restricted movement from 5/5/26 to 5/14/26, which created a backlog.[53] The staff reported nursing had a backlog of eight, the provider had a backlog of four, and the LVN had a backlog of three. However, they shared they have a plan in place to address the backlog by adding the backlog patients to the nurse and provider lines. The A yard nurse shared they have two RNs on A yard who cover both A yard and M yard, and they triage between 20 and 24 sick call requests per day from each yard. The clinic nurses serve both the role as the primary care nurse and the care manager. They attend population management meetings every two weeks where they discuss patient care concerns and place orders. The patients are scheduled every six months with the provider, and patient labs are completed every three months. The nurses often see patients and provide education for those patients who are non-compliant with medications or treatments.

We interviewed nursing leadership who reported current and completed quality improvement projects to include the No-call/No-show initiative, which requires nursing staff to conduct in-person encounters when patients fail to report for scheduled appointments or medication administration. Additional initiatives include the medication transfer process, the durable medical equipment (DME) project, a project to address healthcare grievances, and the virtual Physical Therapy project that aims to reduce patient refusals. Nursing leadership also reported they are second highest out of all 31 California correctional institution healthcare programs for learning management systems (LMS) training compliance.[54] The CNE incorporated a third training day in annual nursing block training

Photo 15. D clinic RN exam room.
Photograph taken 5-20-2026.

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

[54] Learning Management Systems (LMS) is a software application used for planning, delivering, and tracking training and educational programs.

specifically designated for LMS training, which has shown to be successful in meeting training compliance.

Case Review Recommendations

- Nursing leadership should determine the root causes of challenges preventing nurses from completing thorough face-to-face assessments, co-consulting with providers when needed, and documenting complete assessments and interventions. Leadership should implement and monitor remedial measures as appropriate.

Provider Performance

In this indicator, OIG clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. We assessed the institution's providers' performance in evaluating, diagnosing, and managing their patients properly. We also examined provider performance across several clinical settings and programs, including emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing.

Provider Performance: Case Review Ratings and Results Summary

Case review found WSP providers performed variably in caring for their patients. Provider continuity was excellent. Providers performed sufficiently with outpatient assessment and decision making, outpatient review of records, emergency care, chronic care, and specialty services. However, providers needed to improve with care for specialized medical housing patients and sending complete patient test result notification letters. In addition, 17 of the 55 provider performance deficiencies (31%) related to documentation quality. Fortunately, most of these documentation lapses did not significantly increase medical risk for the patients. After careful consideration of all provider performance factors, the OIG rated this indicator ***adequate.***

Case Review Results

Table 22. Case Review Provider Performance Results

Provider Encounters*	Deficiencies†	Significant Deficiencies‡
78	55	28

* The OIG reviewed 78 provider encounters. This includes events where providers directly interacted with the patient, and does not include co-consults in the outpatient, on-call, and urgent events.

† Deficiencies occurred in cases 1–4, 6–13, 15, 17, 27–29, and 30.

‡ Significant deficiencies occurred in cases 1–2, 4, 6, 8, 10–13, 15, 17, and 28–30.

Table 23. Provider Performance Detailed Cases Results

Total Detailed Cases Reviewed	Proficient	Adequate	Inadequate
20	0	16	4

Performed Well

OIG clinicians found WSP performed well in the following area:

- Provider Continuity[55]

  WSP performed well in this area, particularly when factoring WSP's mission as a Reception Center. WSP leadership reported several hundred patients arrive and leave each week.

Performed Satisfactorily with opportunities for improvement

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

- Outpatient Assessment and Decision-Making

  OIG clinicians identified 10 provider deficiencies in the outpatient setting, with six related to decision-making, one related to poor subjective assessment, one related to poor objective assessment, one related to not ordering appropriate follow-up, and one related to late evaluation of the patient.[56] The following are examples:

  - In case 6, the patient was evaluated in a hospital emergency department for somnolence, possibly due to a combination of mental health medications.[57] WSP staff scheduled a provider appointment for the patient in five days. At the time of the appointment, the provider documented the patient was "not brought in a timely fashion by custody." However, the provider rescheduled the patient thirty days later instead of for a shorter interval. As a result, no medical provider reviewed his medications.

  - In case 28, the nurse co-consulted the clinic provider about a patient with nausea, vomiting, and abdominal pain in his right lower side. Given the location and symptoms, the provider should have considered the diagnosis of appendicitis.

[55] A minor deficiency occurred in case 2.

[56] Significant deficiencies occurred in cases 6, 8, 10, 11, and 28. Minor deficiencies occurred in cases 7, 10, and 11.

[57] Somnolence is a condition, ranging from mild to excessive, of sleepiness that interferes with normal functioning, which may indicate underlying sleep disorders, metabolic imbalances, or neurological issues.

Instead, the provider ordered a five-day nurse follow-up appointment instead of evaluating the patient face-to-face. However, the patient continued to have abdominal pain and was seen later the same day in the TTA. TTA staff evaluated the patient and transferred the patient to the hospital for appendicitis.

- In case 11, the provider assessed the patient with a history of uncontrolled diabetes for a skin infection. While the provider ordered antibiotics, the provider did not order follow-up appointments to ensure the patient's skin infection was monitored appropriately. Later in this case, the patient developed facial swelling and problems swallowing. The provider did not examine the patient's oropharynx to determine the extent of swelling.

- Outpatient Review of Records

  Providers generally reviewed outpatient records sufficiently to provide informed care. However, OIG clinicians identified three minor deficiencies and the following significant deficiency:[58]

  - In case 12, the provider increased two diabetes medications at the same time in a patient with uncontrolled diabetes without reviewing the medication administration record to recognize the patient had not been taking his medications. This increased the patient's risk for low blood sugars if the patient took all his medications.

- Emergency Care

  Providers in the TTA usually triaged the patients appropriately. We identified four minor deficiencies and discuss the significant deficiency in the **Emergency Services** indicator.[59]

- Chronic Care

  Providers managed high blood pressure and anticoagulation well. However, diabetes care could be improved. OIG clinicians identified six deficiencies related to diabetes care, four of which were significant, all in one case.[60] The following are two examples:

  - In case 10, the provider did not perform a monofilament exam to check for nerve damage in a patient with diabetes because a tool was not available.[61]

[58] A significant deficiency occurred in case 12. Minor deficiencies occurred in cases 11, 17, and 27.

[59] A significant deficiency occurred in case 11. Minor deficiencies occurred in cases 1, 3, 11, and 28.

[60] Significant deficiencies occurred in cases 10 and 11. Minor deficiencies occurred in cases 7 and 11.

[61] At the OIG clinician on-site inspection, the CME reported personally going to each clinic and the storage warehouse to confirm medical tools were readily available.

- On four separate occasions in case 11, the provider evaluated the diabetic patient for concerns involving a finger wound, discussion of medications, a facial infection, and a different subsequent facial infection, respectively. However, the provider did not address the patient's highly elevated hemoglobin A1c of 12.2 at any of these appointments.[62]

- Specialty Services

Providers generally referred patients when medically indicated and followed specialists' recommendations. OIG clinicians identified one minor deficiency and four significant deficiencies.[63] Of these significant deficiencies, we attributed three to WSP providers, and one to a department headquarters provider.[64] The following is an example of a deficiency we attributed to a WSP provider.

- In case 8, the dietician recommended the patient be referred to an allergy or immunology specialist for reported food allergies. However, the provider did not order the recommended specialist referral.

The following is the significant deficiency we attributed to the department headquarters provider:

- In case 6, the CCHCS headquarters addiction medicine specialist did not properly review the patient's medical record and medications to recognize the patient was recently evaluated in a hospital emergency department for somnolence due to medications, and the patient was already taking four medications that can affect the central nervous system. The provider started the patient on suboxone, which could increase the effects of the four medications, and did not ensure careful monitoring.[65] This significantly increased the risk of harm for the patient. Three days later, the patient was found unresponsive and, despite resuscitative efforts, passed away.

Please refer to the **Specialty Services** indicator for further discussion.

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[62] Hemoglobin A1c (HbA1c) is a blood test that measures the average plasma glucose over the previous 12 weeks. For most patients with diabetes, the HbA1c goal is 7 percent or less. See https://www.cdc.gov/diabetes/diabetes-testing/prediabetes-a1c-test.html. An elevated HbA1c of 12.2 increases the risk of infection and delayed healing.

[63] A minor deficiency occurred in case 11. Significant deficiencies occurred in cases 6, 8, and 30.

[64] Significant deficiencies attributable to WSP providers occurred in cases 8 and 30. All of these deficiencies were instances of the provider not following the specialist's recommendations.

[65] Suboxone is a medication containing buprenorphine and naloxone. Suboxone is used to treat opioid dependence and addiction.

Performed Poorly, Improvement Needed

OIG clinicians found WSP performed poorly with improvement necessary in the following areas:

- Outpatient Documentation Quality

  OIG clinicians identified 17 documentation deficiencies.[66] Most related to lack of provider documentation with nursing co-consults. Three deficiencies related to providers not documenting the medical rationale for their decisions. Two deficiencies related to missing outpatient provider progress notes. The following are examples:

  - In case 10, on two occasions, the same provider did not document a progress note. The EHRS showed the medical assistant checked the patient in but contained no evidence of provider evaluations.
  - Also in case 10, the nurse co-consulted the provider about a possible infection in the patient's lower extremities. The nurse entered orders for x-rays, an antibiotic, and a diuretic medication. The nurse documented, "provider to see patient," but the provider did not document a progress note.
  - In case 11, the TTA provider evaluated the patient for a finger laceration, and the nurse cleaned the wound and applied a dressing; however, the provider did not document a progress note.
  - In case 30, the CTC provider documented a progress note with only "S:" in the body of the progress note.

- Specialized Medical Housing

  OIG clinicians found WSP providers evaluated CTC patients in appropriate rounding intervals. However, we identified 11 provider performance deficiencies in three cases.[67] The following are examples:

  - In case 4, the patient with a weak heart was discharged by the hospital provider with recommendations for medications to help improve his heart function. On admission to the CTC, the WSP provider discontinued several of the medications, ordered one of the medications at a higher dose than recommended by the hospital provider, and ordered medication administration parameters that reduced the likelihood the patient would receive his heart medication. Consequently, the patient did not receive the appropriate medications. The

[66] Significant deficiencies occurred in cases 10, 13, and 30. Minor deficiencies occurred in cases 3, 7, 8, 10–12, 15, and 28–30.

[67] Significant deficiencies occurred in cases 4 and 30. Minor deficiencies occurred in cases 29 and 30.

patient was hospitalized four days later and eventually passed away in the hospital from a heart attack and heart failure.

- In case 30, the patient was discharged from the hospital after treatment for infection of the spine and surrounding tissue with intravenous antibiotics. The hospital provider recommended the patient follow up with the infectious disease specialist and neurosurgery specialist. On multiple occasions, spanning one and a half months, the provider continued to document that follow up with specialists would occur, but never ordered the specialty referrals. This delay resulted in the infectious disease specialist follow-up appointment occurring after the IV antibiotic treatment was completed.

- Also in case 30, once the appointment with the infectious disease specialist occurred, the specialist recommended oral antibiotics for eight weeks. The WSP provider was concerned about side-effects from this antibiotic and decided not to start the medication until the provider could contact the specialist. However, this consultation did not occur for several days, causing delay. Then, before the WSP provider could order the correct medication, the patient transferred to a different institution. The provider at the new institution spoke with the infectious disease specialist and started the patient on a different antibiotic. The WSP provider's delay, compounded with the delay in ordering the infectious disease specialist consult cited in the above deficiency, resulted in the patient not receiving antibiotics for six days. This was a critical lapse in treatment because recent imaging still showed "mild paraspinal and minimal epidural infection."

We also discuss Provider Performance in the **Specialized Medical Housing** indicator.

- Patient Notification Letters

  OIG clinicians identified 29 deficiencies with patient test result notification letters.[68] Twenty of the deficiencies related to missing letter elements while nine related to providers not sending letters. We discuss with detail in the **Diagnostic Services** and **Health Information Management** indicators.

[68] Minor patient test result notification letter deficiencies occurred in cases 2, 7, 8, 10, 12–14, and 30.

Clinician On-Site Inspection

During our on-site inspection, OIG clinicians attended two huddles. The patient care teams showed familiarity with the patients and their medical problems. During the morning provider meetings, the CP&S moderated the meeting and relayed information from the primary provider-on-call (POC). The secondary POC also spoke about the contact from patients' nurses the previous night. In addition, the providers discussed a medically challenging case and possible approaches to determine a diagnosis. The providers showed a high level of collaboration.

We spoke with the chief medical executive (CME) and the chief physician & surgeon (CP&S), who were very content with their providers. Only one primary care physician, the CP&S, and three advanced practitioners worked as on-site state employees. WSP also used two CCHCS headquarters telemedicine primary care providers. The remaining providers were registry staff. Medical leadership expressed difficulty with hiring state providers due to the pay differential deficit they have when compared to the nearby institution, North Kern State Prison.

We also spoke with several providers. The providers reported no issues with ancillary staff orders or backlogs. In general, they expressed their great appreciation for their CME and CP&S. They stated the medical leadership was available to help, and they all affirmed WSP was the best institution for which they have worked. Providers indicated they maintained good relationships with nursing staff and custody, but they felt nursing staff could communicate better.

Case Review Recommendations

- Medical leadership should develop, implement, and monitor strategies to ensure providers document appropriate progress notes for consultations with nursing staff, both during the clinic and on-call hours, for clear communication and collaboration with the patient care team and to promote good continuity of patient care.

Reception Center

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the department's system. The OIG review includes evaluating the institution's performance in 1) providing and documenting initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests and provider focused health care assessment; 2) addressing and providing significant accommodations for disabilities and health care appliance needs; and 3) identifying health care conditions needing treatment and monitoring. Patients reviewed for reception center (RC) care are those received from nondepartmental facilities, such as county jails.

Reception Center: Case Review Ratings and Results Summary

WSP reception center delivered excellent care. Nurses performed well in assessments, interventions, and documentation for patients arriving to the RC. Nurses reviewed health records from county jails and appropriately referred to providers. The institution also performed well in ensuring medication continuity. In addition, providers conducted evaluations, and staff performed required on-site diagnostic tests in a timely manner. Considering all factors, the OIG rated the case review component of this indicator ***proficient***.

Case Review Results

Table 24. Case Review Reception Center Results

Reception Center Events *	Deficiencies†	Significant Deficiencies‡
18	3	0

* The OIG reviewed 18 reception center events in cases 2–4, 9, 24–26, 28, and 29.

† Deficiencies occurred in cases 2, 9, and 28.

‡ The OIG identified no significant deficiencies.

Performed Well

OIG clinicians found WSP performed well in the following:

- Nursing Performance[69]
- Medication Management[70]
- Provider Access[71]
- Diagnostic Access[72]

Performed Satisfactorily with Opportunities for Improvement

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

Performed Poorly, Improvement Needed

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

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

[70] Medication management deficiencies occurred in cases 2 and 28. No significant deficiencies occurred.

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

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

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians interviewed the receiving and release (R&R) RN and the nursing supervisor. As discussed in further detail in the **Transfers** indicator, WSP has an average of 373 patients arriving per week, which includes all transfer-in and reception center patients.

Photo 16. Receiving and Release hallway of PCP exam rooms. Photographed 5-19-2026.

The R&R staff were knowledgeable about their job duties and the reception intake process. Please see the **Transfers** indicator for more details. The staff explained a provider must evaluate the patients who arrive from the county jail within seven days. Additionally, staff must complete labs, diagnostics, dental, mental health, and optometry appointments. The nursing supervisor reported their goal of completing the entire intake process within one day for each incoming patient. WSP had recently renovated the R&R area, and we found the area was clean and well organized. The staff reported they felt supported by nursing leadership and have a cohesive relationship with custody staff.

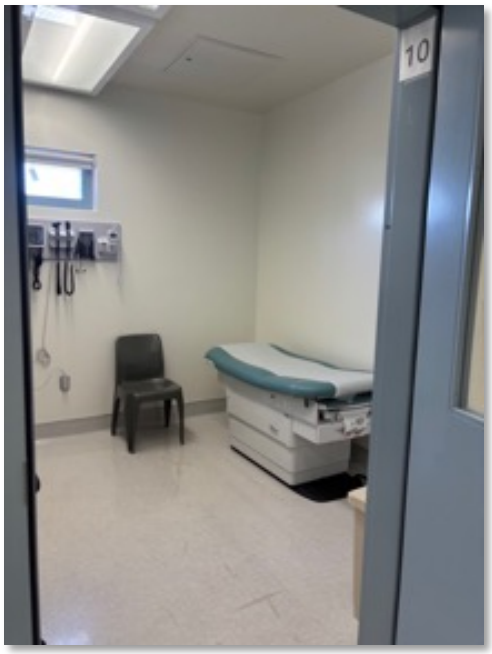


Photo 17. Receiving and Release PCP exam room. Photographed 5-19-2026.

Case Review Recommendations

The OIG offers no Case Review recommendations for this indicator.

Reception Center: Compliance Rating and Results Summary

Compliance Rating
ADEQUATE
Compliance Score
(84.4%)

WSP demonstrated good performance for this indicator. Based on the overall compliance score, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- Nursing staff demonstrated proficiency in completing initial health screenings and answering all screening questions within the required time frames for all 20 sampled patients (MIT 12.001, 100%).
- Nursing staff showed proficiency in completing the assessment and disposition sections of the initial health screening form for all 18 applicable sampled patients (MIT 12.002, 100%).
- Providers evaluated the patients and performed history and physical examinations for all 20 patients within the required time frames (MIT 12.004, 100%).
- The institution offered and completed screening laboratory tests within the specified time frames for 18 of 20 sampled patients (MIT 12.005, 90.0%). For two patients, the record contained no evidence of a signed refusal form for the refused screening laboratory tests.
- The institution demonstrated proficiency in ensuring a Coccidioidomycosis (Valley Fever) skin test was offered, administered, read, or refused timely for all 20 sampled patients (MIT 12.007, 100%).

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

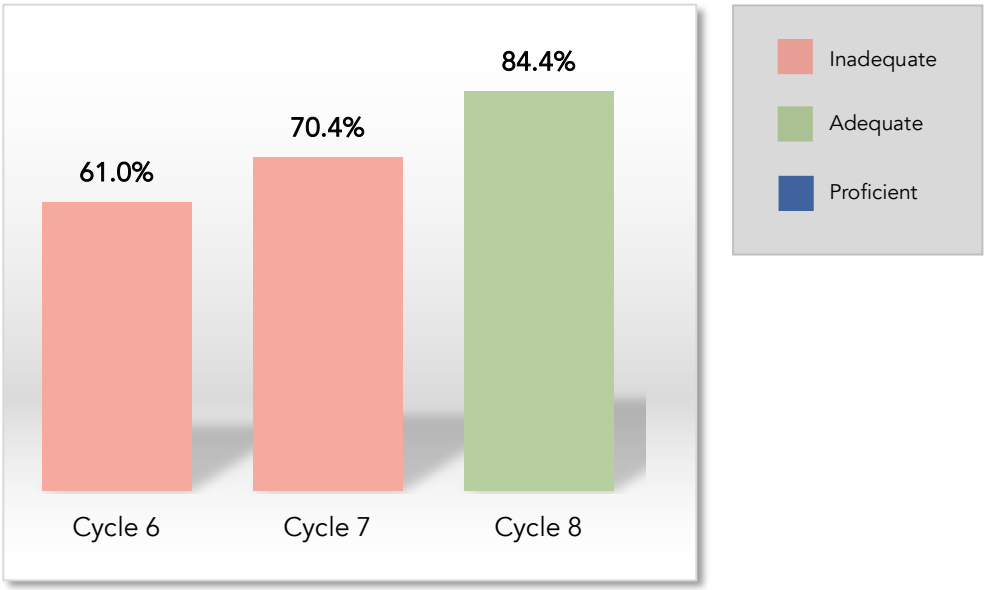
- Healthcare providers generated patient notification letters for laboratory reports with all required elements within specified time frames for only three of 18 applicable sampled patients (MIT 12.006, 16.7%). For 15 patients, we found one or more of the following deficiencies: patient letters were missing key elements as required by policy; patient letters were not generated at the time of provider review and endorsement of the laboratory results; or the record contained no evidence of patient letters generated for several patients.

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

- The compliance test for MIT 12.003 in this indicator was deemed not applicable during the reporting period. Upon arrival from the county jail, patients were assessed by nursing staff, and no provider referrals were generated outside of the required appointment for history and physical examinations.

Analysis of Performance Across Inspection Cycles

Figure 9. Reception Center, Compliance Scores Across Cycles



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

In Cycle 8, WSP performed above established standards for the **Reception Center** indicator, successfully meeting the requirements for this cycle. The institution met the 75.0 percent passing compliance threshold for this indicator, reaching a nearly ***proficient*** score of 84.4 percent in Cycle 8. This score follows previous ***inadequate*** performance results of 61.0 percent in Cycle 6 and 70.4 percent in Cycle 7. This significant improvement indicates the institution has achieved a successful return to meeting established benchmarks through steady, positive growth, now performing in the ***adequate*** range in Cycle 8.

Compliance Score Results

Table 25. Reception Center Compliance Score Results

Compliance Questions	Scored Answers			
	Yes	No	N/A	Yes %
For patients received from a county jail: Did nursing staff complete the initial health screening and answer all screening questions? (12.001)	20	0	0	100%
For patients received from a county jail: Did the RN complete the assessment and disposition section, and sign and date the completed health screening form upon patient's arrival at the reception center? (12.002)	18	0	2	100%
For patients received from a county jail: If during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	0	0	20	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within five working days? (12.004)	20	0	0	100%
For patients received from a county jail: Were all screening tests offered or completed within specified timelines? (12.005)	18	2	0	90.0%
For patients received from a county jail: Did the health care provider review the screening test results and generate the patient notification letter with all required elements within the specified time frame?	3	15	2	16.7%
For patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely?	20	0	0	100%
				Overall percentage (MIT 12): **84.4%**

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

Compliance Recommendations

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

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

Specialized Medical Housing: Case Review Ratings and Results Summary

In case review, WSP needed improvement in specialized medical housing (SMH) medical care. Nurses and providers sufficiently evaluated patients timely and administered medications without a lapse in continuity. However, our clinicians identified patterns of incomplete nursing admission assessments, incomplete daily nursing assessments, and staff not always providing appropriate interventions for patients who had a change in condition. Moreover, provider performance was poor with questionable medical descision making and missing documentation. Considering all factors, the OIG rated the case review component of this indicator ***inadequate.***

Case Review Results

Table 26. Case Review Specialized Medical Housing Results

CTC Events*	Deficiencies†	Significant Deficiencies‡
75	30	12

* We reviewed six CTC cases that included 28 provider encounters and 25 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 4 and 28–30.

‡ Significant deficiencies occurred in cases 4, 29, and 30.

Performed Well

OIG clinicians found WSP performed well in the following:

- Medication Management[73]

  Our clinicians found almost all medications were administered without a lapse in continuity. Our clinicians identified only one significant deficiency below:

  - In case 29, the patient refused his blood pressure medication. The nurse took his vital signs and obtained a significantly low blood pressure reading. However, on one occasion, the nurse did not notify the provider of the abnormal finding.

Performed Satisfactorily with Opportunities for Improvement

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

Performed Poorly, Improvement Needed

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

- Nursing Performance[74]

  OIG clinicians found CTC nurses conducted nursing rounds timely and performed daily nursing assessments. However, in four of the six cases, WSP nurses performed incomplete assessments when patients were admitted to the CTC.[75] Our clinicians also identified a trend in incomplete assessments, and nurses did not always perform appropriate interventions. The following are examples:

  - In case 4, the CTC RN documented a significantly low blood pressure reading. However, the nurse did not assess the patient for signs and symptoms of the low blood pressure reading, notify the provider of the abnormal finding, and delayed reassessing the patient's blood pressure for three hours. On another occasion, the patient reported symptoms of shortness of breath, and the RN obtained vital signs which showed a low blood pressure reading. However, the RN did not perform a cardiac or respiratory assessment, including listening to heart or lung sounds, and did not notify the provider of the patient's change in condition.

[73] One significant medication management deficiency occurred in case 29.

[74] Nursing encounters occurred in cases 4 and 28–32. Deficiencies occurred in 4, 28, 29, and 30. Significant deficiencies occurred in cases 4, 29.

[75] Nursing performance admission assessment deficiencies occurred in cases 4 and 28–30.

- In case 28, the patient was admitted to the CTC for IV antibiotic therapy following hospital discharge after surgical removal of the appendix with three surgical incisions. The patient also had a Jackson-Pratt (JP) drain and a midline catheter.[76] The nurse did not perform an assessment to establish the baseline condition of the midline catheter, assess the surgical sites, or assess the color and amount of wound drainage in the JP.

- In case 29, the patient was admitted to CTC for assistance with activities of daily living. The patient fell on the floor; however, CTC nursing staff did not perform an initial post-fall assessment. The provider eventually evaluated the patient two hours later.

- In case 30, the patient was admitted to the CTC with a peripherally inserted central catheter (PICC) line for IV antibiotic therapy post hospitalization for osteomyelitis.[77] The RN did not perform a thorough PICC line assessment to the left upper arm to include measuring the external catheter length or document the patient's left upper arm circumference. Additionally, from 12/2/25 to 12/15/25, nursing staff performed daily PICC line care; however, nursing staff frequently did not perform PICC line flushes before or after administering antibiotic therapy or document the PICC line external length or left arm circumference.

- Provider Performance

  OIG clinicians reviewed 28 specialized medical housing provider encounters in six cases and found eleven deficiencies, seven of which were significant.[78] The deficiencies included not following hospital recommendations, missing documentation, and questionable medical decision-making. Provider performance deficiencies are discussed in more detail in the **Provider Performance** indicator. The following are examples:

  - In case 4, the provider evaluated the recently hospitalized patient to follow up on test results and severe heart failure. The provider had originally planned to start a new medication; however, the provider did not follow through on this plan. In addition, the provider did not discuss the results of the recent cervical x-rays and thoracic x-rays with the patient.

  - In case 30, a provider documented that nursing reported a "noticeable discoloration on IV line," due to possible patient tampering. Five days later, the nurse noted examination findings possibly indicating infection. The provider

[76] A Jackson-Pratt (JP) drain is a surgical tool used to remove extra blood and fluid from a wound while it heals.

[77] A peripherally inserted central catheter (PICC) provides intravenous access to administer fluids and medication. Osteomyelitis is an infection of the bone.

[78] Specialized medical housing provider events occurred in cases 4, 29, and 30. Significant deficiencies occurred in cases 4 and 30.

should have evaluated the patient immediately to evaluate for infection instead of the next day.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians interviewed the CTC lead nurse. The CTC staffing consists of three RNs on each shift, which includes a lead RN, as well as an LVN and psychiatric technician on the day and evening shift. The CTC has a designated provider Monday through Friday, and the on-call provider covers after hours.

The CTC has six medical beds, six mental health beds, and two negative pressure rooms. Additionally, the CTC has one seclusion room and one padded safety room.[79] During our inspection, the CTC census had six medical patients and six mental health patients. The nurse shared the process for new patient admissions including reconciliation of medications, specialty appointments, hospital recommendations, and PICC line care. The nurse also reported nursing rounds are conducted every one to two hours, depending on the condition of the patient, and provider and nurse rounds are conducted daily. The nurse reported they have great leadership and felt supported in their role.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure CTC nursing staff perform thorough patient assessments, recognize changes in patient status, and intervene timely and appropriately. Leadership should implement and monitor remedial measures as appropriate.
- Medical leadership should review the factors that may preclude specialized medical housing providers from documenting all pertinent physical examination findings and should implement and monitor remedial measures as appropriate.

[79] A seclusion room is a specially designed room where a patient who is in a severe mental health crisis may be placed alone for a short period of time if they are a danger to themselves or others. A padded safety room has soft impact resistant walls and furnishings to reduce the risk of injury.

Specialized Medical Housing: Compliance Ratings and Results Summary

WSP performed exceptionally in this indicator. Based on the overall compliance score, the OIG rated the compliance component of this indicator ***proficient.***

Compliance Testing Results

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

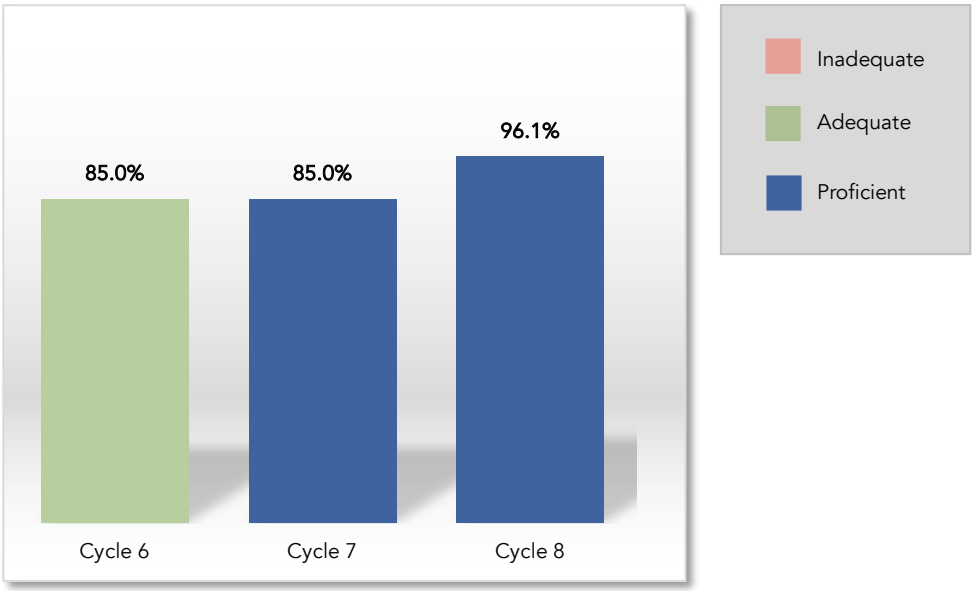
- Registered nurses (RNs) demonstrated good performance in completing an initial assessment of the patient at the time of admission for all 10 sampled patients (MIT 13.001, 100%).
- Providers performed excellently in completing written history and physical examinations within the required time frames for all 10 sampled patients (MIT 13.002, 100%).
- Providers exhibited proficiency in ordering medications within the required time frames upon the patient's admission for all 10 sampled patients (MIT 13.003.1, 100%).
- Health care staff ensured all ordered medications were made available for seven of eight applicable sampled patients within the required time frames (MIT 13.003.2, 87.5%). For one patient, 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 eight of nine applicable sampled patients within the required time frames (MIT 13.003.3, 88.9%). For one patient, we found the following deficiencies: nursing staff did not administer nurse-administered (NA) medications within the provider's ordered timelines, and nursing staff did not document the patient's stated reason for refusing medication.
- The institution maintained an operational call light system during the on-site inspection (MIT 13.101, 100%).

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

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

Analysis of Performance Across Inspection Cycles

Figure 10. Specialized Medical Housing, Compliance Scores Across Cycles



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

In Cycle 8, WSP continued to perform above established standards. The institution successfully exceeded the 75.0 percent passing compliance threshold for this indicator, reaching a ***proficient*** score of 96.1 percent in Cycle 8. This score demonstrates a further increase from the scores of 85.0 percent recorded in both Cycle 6 and Cycle 7,[80] highlighting sustained excellence and continuing positive growth in this indicator.

[80] In Cycle 6, a score of 75.0% through and including 85.0% was considered within the ***adequate*** range. However, starting in Cycle 7, the OIG amended its methodology to include a score of 85.0 and above within the ***proficient*** range, and we redefined the ***adequate*** range as 75.0% up to but not including 85.0%.

Compliance Score Results

Table 27. 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)	10	0	0	100%
Was a written history & physical examination completed within the required time frame? (13.002)	10	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)	10	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)	7	1	2	87.5%
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)	8	1	1	88.9%
For specialized health care housing: Do specialized health care housing maintain an operational call system? (13.101)	1	0	0	100%
For specialized health care housing): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	1	N/A
Overall percentage (MIT 13): **96.1%**				

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

Compliance Recommendations

The OIG offers no compliance recommendations for this indicator.

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 WSP performed satisfactorily in delivering specialty services for its patients. Specialty service appointments and procedures usually occurred within the ordered time frames. Providers generally completed appropriate follow-up appointments, and nurses usually performed complete assessments. Additionally, WSP managed health information sufficiently and scanned specialty and procedure reports timely. After reviewing all factors, the OIG rated the case review component of this indicator ***adequate***

Case Review Results

Table 28. Case Review Specialty Services Results

Specialty Services Related Events*	Deficiencies†	Significant Deficiencies‡
49	14	8

* The OIG reviewed 49 events, including 47 specialty consultations and procedures and two nursing encounters.

† Deficiencies occurred in cases 6–8, 11, 16–17, 28, 30, and 32.

‡ Significant deficiencies occurred in cases 6–8, 11, and 30.

Performed Well

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

Performed Satisfactorily, with Opportunities for Improvement:

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

- Access to Specialty Services[81]

  Specialty service appointments generally occurred on time. OIG clinicians identified only two deficiencies. The following is an example:

  - In case 30, the provider ordered a neurosurgery specialty referral. However, the neurosurgery specialty appointment did not occur as ordered or within the review period.

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

- Health Information Management[82]

  WSP usually retrieved specialty reports and providers generally reviewed them timely. OIG clinicians identified only one significant deficiency as follows:

  - In case 11, the optometrist evaluated the patient for diabetic eye examination. However, a provider did not review the optometrist's report.

  WSP's handling of specialty services reports is also detailed in the **Health Information Management** indicator.

- Provider Performance[83]

  OIG clinicians found providers generally ordered specialty service referrals and procedures in a timely manner and with appropriate priority. Providers usually followed through with specialists' recommendations and completed appropriate post-specialty

[81] Two significant deficiencies in specialty care access occurred in cases 7 and 30.

[82] One significant deficiency occurred in case 11. Four minor deficiencies occurred in cases 16, 28, and 32.

[83] Four significant deficiencies occurred in cases 6, 8, and 30. One minor deficiency occurred in case 11.

assessments. However, OIG clinicians identified four significant deficiencies, and the following is one example:

- In case 30, the provider ordered an infectious disease specialty referral after repeatedly documenting "F/U ID in 3 weeks."[84] The follow-up appointment with the infectious disease specialist should have occurred three weeks after the hospital discharge date. However, the infectious disease appointment occurred over a month late.

Please see the **Provider Performance** indicator for further information.

- Nursing Performance[85]

  OIG clinicians reviewed two nursing encounters for patients who returned to WSP after an off-site specialist appointment and identified one significant deficiency:

  - In case 30, the patient returned to WSP after an off-site infectious disease specialty appointment. The nurse did not perform an assessment and did not review the specialist's recommendations.

Performed Poorly, Improvement Needed

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

Clinician On-Site Inspection

OIG clinicians discussed specialty services processes and deficiencies with WSP health information management supervisors, utilization management (UM) nurse, office technicians, ancillary staff, diagnostic staff, nurses, and providers. During our case reviews, we found examples of providers ordering specific specialty service referral priority levels and modifying the referral completion date to a sooner date. The UM nurse reported staff try to schedule by the completion dates the providers requested, but the completion dates should not extend across priority levels.

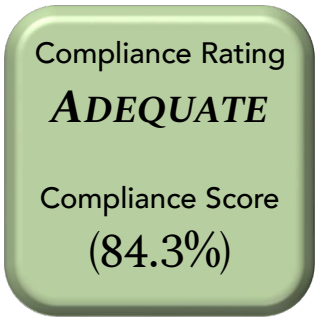
Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

[84] "F/U" is medical shorthand for "follow up." "ID" is medical shorthand for "infectious disease."

[85] One significant deficiency occurred in case 30.

Specialty Services: Compliance Ratings and Results Summary



WSP performed well in this indicator. Based on the overall compliance score, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- The institution achieved proficiency in ensuring providers review the high-priority specialty service consultant report within the required time frames in all 14 applicable sampled patients (MIT 14.002.2, 100%).
- The institution provided subsequent follow-up appointments after a high-priority specialty service for all seven applicable sampled patients (MIT 14.003, 100%).
- The institution received medium-priority specialty service consultant reports within the required time frames for 13 of 15 sampled patients (MIT 14.005.1, 86.7%). For two patients, the reports were received between six and 12 days late.
- The institution achieved proficient performance in ensuring providers review the medium-priority specialty service consultant report within the required time frames for 14 of 15 sampled patients (MIT 14.005.2, 93.3%). For one patient, the provider reviewed the report three days late.
- The institution ensured patients timely received their routine-priority specialty services within 90 calendar days for all 15 patients (MIT 14.007, 100%).
- The institution performed satisfactorily in providing subsequent follow-up appointments after a routine-priority specialty service for all seven sampled patients (MIT 14.009, 100%).

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

- The institution received high-priority specialty service consultant reports within the required time frames for 12 of 15 applicable sampled patients (MIT 14.002.1, 80.0%). For two patients, the reports were received between six and seven days late. For the remaining patient, the record contained no evidence the institution received the specialist report.

- The institution ensured providers reviewed the routine-priority specialty service consultant report within the required time frames for 11 of 13 applicable sampled patients (MIT 14.008.2, 84.6%). For two patients, the provider reviewed the report three days late.

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

- The institution ensured patients received high-priority specialty services within 14 calendar days for 11 of 15 patients (MIT 14.001, 73.3%). For four patients, the service was provided between four and 38 days late.

- The institution ensured patients received medium-priority specialty services within 15 to 45 calendar days for 11 of 15 sampled patients (MIT 14.004, 73.3%). For four patients, the service was provided between three and 55 days late.

- The institution provided subsequent follow-up appointments after a medium-priority specialty service for five of seven applicable sampled patients (MIT 14.006, 71.4%). For two patients, the provider failed to document whether they agreed or disagreed with the specialists' recommendations, as required by policy.

- The institution received routine-priority specialty service consultant reports within the required time frames for eight of 13 applicable sampled patients (MIT 14.008.1, 61.5%). For five patients, the reports were received between one and seven days late.

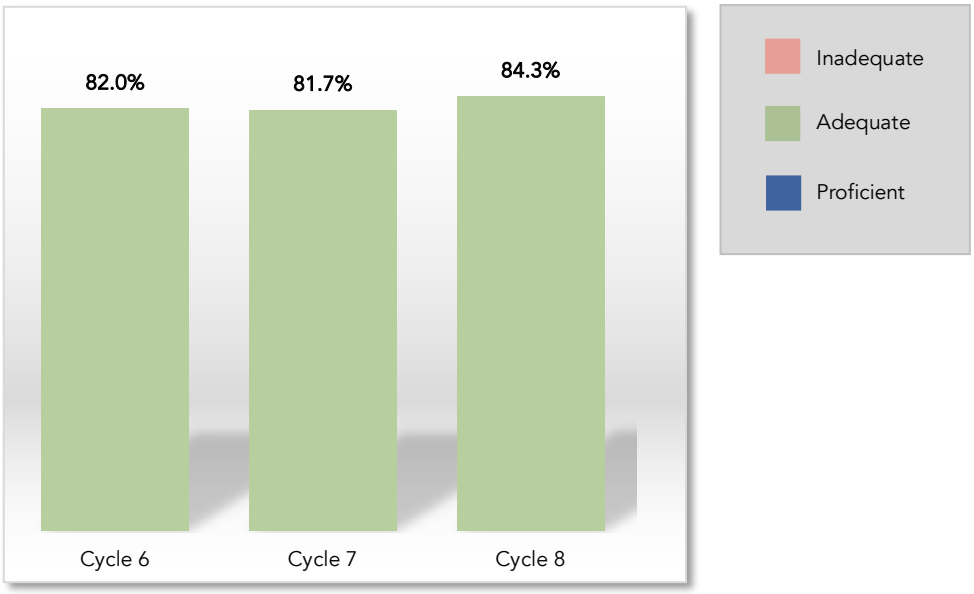
- The institution ensured patients timely received their pre-approved specialty service appointments for patients endorsed from another institution in 10 of 14 sampled patients (MIT 14.010, 71.4%). For two patients, the services were provided two and 38 days late. For the remaining two patients, the 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 for MITs 14.011 and 14.012 were deemed not applicable during the reporting period as the OIG 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 11. Specialty Services, Compliance Scores Across Cycles



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

In Cycle 8, WSP met established standards, maintaining an ***adequate*** rating since the prior cycles. The institution met the 75.0 percent passing compliance threshold for this indicator, reaching a nearly ***proficient*** rating of 84.3 percent in Cycle 8. WSP's performance has remained consistently stable for the past three cycles, improving slightly from ***adequate*** scores of 82.0 percent in Cycle 6 and 81.7 percent in Cycle 7, indicating the institution continues to perform well within the established benchmarks.

Compliance Score Results

Table 29. Specialty Services Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	11	4	0	73.3%
Did the institution receive the high-priority specialty service consultant report within the required time frame? (14.002.1)	12	3	0	80.0%
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)	7	0	8	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)	11	4	0	73.3%
Did the institution receive the medium-priority specialty service consultant report within the required time frame? (14.005.1)	13	2	0	86.7%
Did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005.2)	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the medium- priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.006)	5	2	8	71.4%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	15	0	0	100%
Did the institution receive the routine-priority specialty service consultant report within the required time frame? (14.008.1)	8	5	2	61.5%
Did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008.2)	11	2	2	84.6%
Did the patient receive the subsequent follow-up to the routine- priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.009)	7	0	8	100%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	10	4	0	71.4%
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):	**84.3%**

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

Compliance Recommendations

- The institution's health care leadership should develop strategies to ensure patients timely receive pre-approved, 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

WSP performed extraordinarily well in this indicator. Based on the overall compliance score, the OIG rated this indicator ***proficient***.

Compliance Testing Results

WSP 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 as well as timely and properly addressed all 10 patient appeals during our review period (MIT 15.101, 100%).

- The institution timely reviewed and completed the initial patient death reports for all six sampled patient deaths (MIT 15.102, 100%).

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

- All 18 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%).

- We obtained CCHCS Mortality Case Review reporting data. The institution's CEO and their designees completed the multidisciplinary review of the significant events leading to all seven patient deaths during our review period (MIT 15.998 [scored component], 100%).

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

- The institution ensured 11 of 14 newly hired nurses completed the required onboarding and clinical competency processes (MIT 15.108, 78.6%). For three nurses, the orientation was completed between two and 42 days late from the required time frame.

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

- The medical leadership did not complete clinicians' performance appraisals timely for either of the two sampled clinicians (MIT 15.104, zero). For the two appraisals, the medical leadership failed to provide a complete Ongoing Professional Practice Evaluation (OPPE) timely.

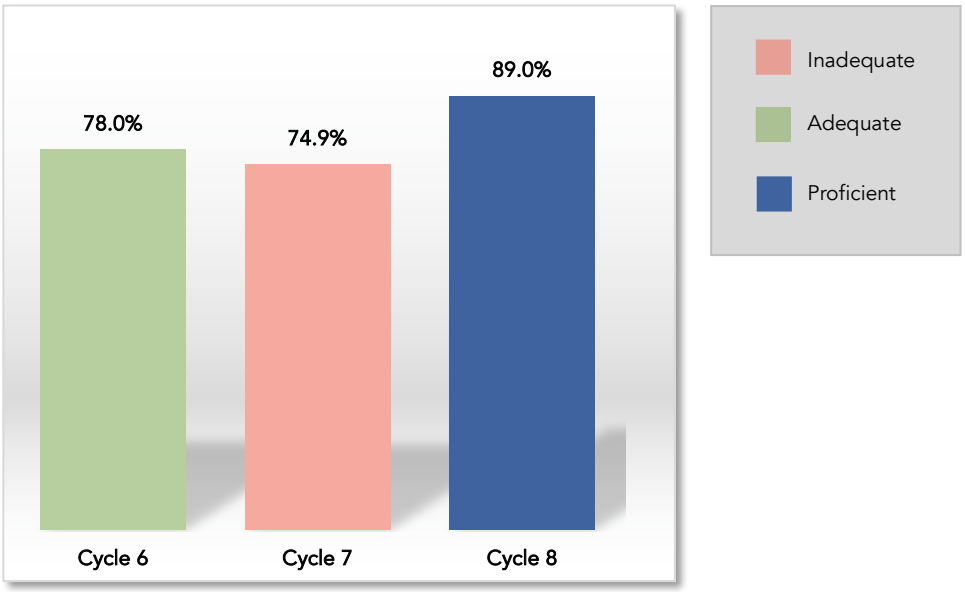
The following tests are not scored but are reported for informational purposes:

- At WSP, 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 any of the seven patient death reports (MIT 15.998 [non-scored component], N/A).

Analysis of Performance Across Inspection Cycles

Figure 12. Administrative Operations, Compliance Scores Across Cycles



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

In Cycle 8, WSP performed above established standards, reaching a ***proficient*** score. The institution surpassed the 75.0 percent passing compliance threshold for this indicator, reaching 89.0 percent in Cycle 8. This score follows a previously ***adequate*** score of 78.0 percent in Cycle 6 and a regression to an ***inadequate*** score of 74.9 percent in Cycle 7. This remarkable improvement demonstrates a strong and successful return to exceeding established benchmarks in this indicator.

Compliance Score Results

Table 30. 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)	6	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.103)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.104)	0	2	2	0
Did the providers maintain valid state medical licenses? (15.105)	18	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)	11	3	0	78.6%
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)?	7	0	0	100%
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This test is not scored. Please refer to Table x for CCHCS- provided staffing information.			
	Overall percentage (MIT 15): **89.0%**			

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

Compliance Recommendations

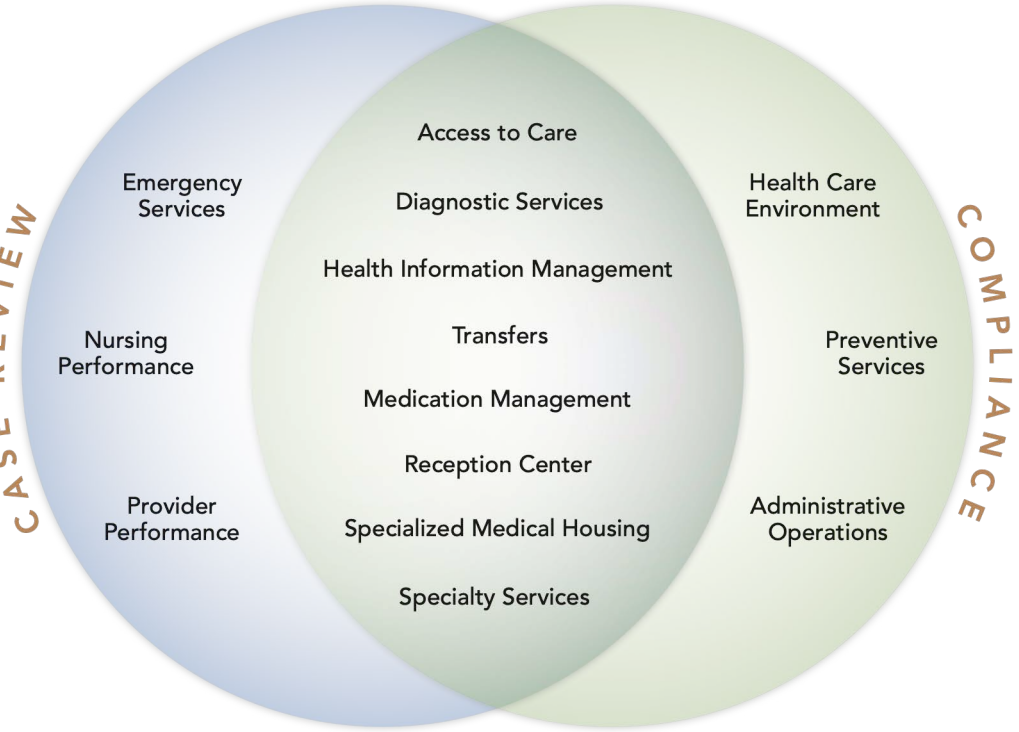
The OIG offers no compliance recommendations for this indicator.

Appendix A: Methodology[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 13. Inspection Indicator Review Distribution for WSP



Source: OIG medical inspection methodology.

[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 8 medical inspections. Below, Table 31 provides important definitions that describe this process.

Table 31. 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

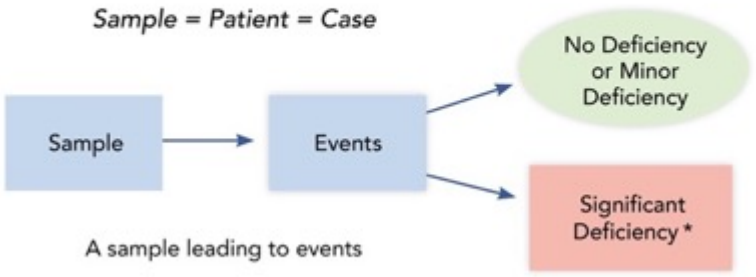
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we 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 14 depicts the possibilities that can lead to these different events.

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

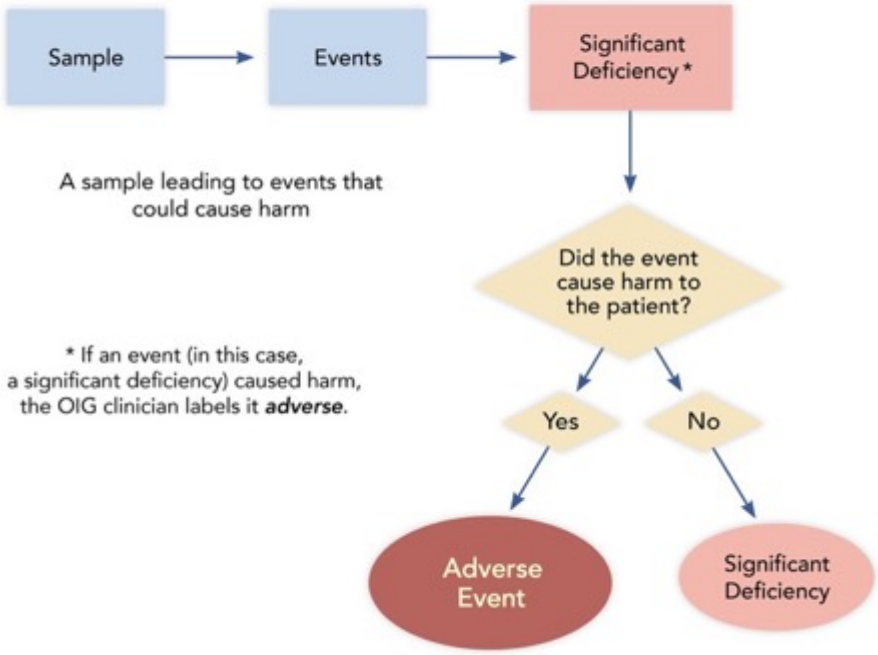
Figure 14. Case Review Testing

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 32. WSP Case Review Sample Sets

Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	4
Diabetes	3
Emergency Services – Non-CPR	2
High Risk	3
Hospitalization	3
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Reception Center Transfers	3
Specialty Services	2
	50

Table 33. WSP Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	1
Anticoagulation	2
Arthritis/Degenerative Joint Disease	2
Asthma	7
Cardiovascular Disease	2
Chronic Pain	4
Cirrhosis/End-State Liver Disease	3
Coccidioidomycosis (Valley Fever)	2
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	5
Gastroesophageal Reflux Disease (GERD)	8
Hepatitis C	10
HIV	4
Hyperlipidemia	11
Hypertension	13
Mental Health	25
Migraine Headaches	1
Seizure Disorder	1
Sleep Apnea	2
Substance Abuse	23
Thyroid Disease	2
	130

Table 34. WSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	88
Emergency Care	32
Hospitalization	19
Intrasystem Transfers In	8
Intrasystem Transfers Out	16
Outpatient Care	240
Reception Center Care	18
Specialized Medical Housing	75
Specialty Services	59
	555

Table 35. WSP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	3
RN Reviews Detailed	14
RN Reviews Focused	29
Total Reviews	66
Total Unique Cases	50
Overlapping Reviews (MD & RN)	16

Appendix C: Compliance Sampling Methodology

Wasco State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (1–7 months) • Randomize
MIT 1.007	Returns From Community Hospital	15	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (30 days–7 months) • Randomize
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (30 days–7 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (30 days–7 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	8	InterQual	• Appt. date (30 days–7 months) • Service (pathology-related) • Randomize
Emergency Services				
MIT 3.001	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MITs 3.101 - 103	Clinical Areas	11	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
MIT 3.104	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 3.105	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question •

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 4.003	Hospital Discharge Documents	15	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	15	CADDIS off-site admissions	• Date (1–7 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	11	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	10	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	20	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	10	Medication error reports	• All medication error reports • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	5	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	25	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (age 45 –75) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 40 –74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 21 – 65) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 9.009	Valley Fever	25	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	20	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	10	CADDIS	• Admit date (1–7 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	14	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)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 15.003	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.102	Death Reports	6	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
Administrative Operations (continued)				
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	4	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.105	Provider Licenses	18	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	7	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

California Correctional Health Care Services' Response

Docusign Envelope ID: 0A4953E1-550A-8FE9-8377-DD2A19C5C597

July 21, 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 Wasco State Prison. 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 III, CCHCS
Chief Executive Officer, WSP
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

Wasco State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2026

OIG