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Independent Prison Oversight

September 2026

Valley 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 sub-indicator tests relating to emergency services into a new compliance indicator, "**Indicator 3. Emergency Services**," to supplement the case review findings under this indicator.[4] Second, we updated our compliance tests in accordance with the department's policy changes and pursuant to discussions with our stakeholders. Third, we updated our case review sampling to reflect stakeholder requests by increasing the number of death reviews, adding evaluation of specialized medical housing encounters within the detailed provider case reviews, and adjusting our case samples to align with current medical practices.[5]

As we did during Cycle 7, the OIG continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. Our statutory mandate provides no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. However, in accordance with the legislature's interest in focusing on the undelegated institutions, the OIG scheduled our medical inspections of the three remaining undelegated institutions earlier in our Cycle 8 inspection calendar.[6] At the time of the Cycle 8 inspection of Valley State Prison, the institution has been delegated back to the department by the receiver (2018).

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

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

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

[7] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The general inspection period includes samples from October 2025 to March 2026, as well as on-site observations during May 2026 and June 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 Valley State Prison (VSP) in June 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 SVSP as ***adequate***.

The OIG rated the compliance component of the overall health care quality at VSP as ***adequate (80.8%)***.

OIG case review clinicians—a team of Physicians & Surgeons (physicians) and Nursing Consultants, Program Review (NCPRs)—reviewed 45 cases, which contained 749 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 June 2026 to verify their initial findings. OIG clinicians evaluated the quality of care for a total of 59 case reviews that included both physician and NCPR comprehensive detailed case reviews and focused case event reviews.[8]

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

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

[8] For our detailed and focused case reviews, our clinicians reviewed medical charts and events for 45 unique patients. Both physicians and NCPRs reviewed 14 of those cases, for a total of 59 detailed and focused case reviews.

department's Health Care Department Operations Manual (HCDOM)[9] by applying a standardized set of test questions that measure specific elements of health care delivery as required under the HCDOM. Our compliance inspectors examined 395 patient records and 1,168 data points, and we used the data to assess 99 MIT questions. We also observed VSP's processes during an on-site inspection in May 2026.

The OIG then considered the results from both our clinical case review and compliance testing, and we determined the institution's overall ratings and our individual indicator findings, which we report in 13 health care indicators.[10]

Overall Medical Inspection Results

Case Review Results

OIG case reviewers assessed 10 of the 13 indicators applicable to VSP. OIG clinicians rated three of these 10 indicators proficient, six adequate, and one inadequate. In the 749 events reviewed, we identified 171 deficiencies, 43 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 VSP during the Cycle 8 inspection.

Compliance Testing Results

Our compliance inspectors assessed 11 of the 13 indicators applicable to VSP. Of these 11 indicators, our compliance inspectors rated six ***proficient***, two ***adequate***, and three ***inadequate***. We solely tested policy compliance in **Health Care Environment**, **Preventive Services**, and **Administrative Operations** as these indicators do not have a case review component.

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

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

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

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

Ratings: Proficient | Adequate | Inadequate

Scoring Ranges: 100%–85.0% | 84.9%–75.0% | 74.9%–0

MIT Number	Health Care Indicators	Case Review Cycle 8	Case Review Change Since Cycle 7*	Compliance Cycle 8	Compliance Cycle 7	Compliance Change Since Cycle 7*
1	Access to Care	Proficient	=	82.1%	91.9%	↓
2	Diagnostic Services	Adequate	=	66.7%	58.1%	=
3	Emergency Services	Inadequate	↓	52.2%	N/A	N/A
4	Health Information Management	Adequate	↑	96.0%	87.0%	=
5	Health Care Environment	N/A	N/A	85.0%	43.0%	↑↑
6	Transfers	Adequate	=	86.9%	56.5%	↑↑
7	Medication Management	Proficient	↑	60.7%	57.0%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	=
9	Preventive Services	N/A	N/A	97.9%	72.8%	↑↑
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%	N/A
13	Specialized Medical Housing	Adequate	=	88.3%	55.6%	↑↑
14	Specialty Services	Proficient	↑	80.8%	69.8%	↑
15	Administrative Operations	N/A	N/A	91.9%	77.6%	↑

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

Institution-Specific Metrics

Valley State Prison (VSP) is located in Chowchilla and houses primarily Level II General Population incarcerated people and those requiring sensitive needs yard (SNY) placements. VSP is designated as a *basic care institution*, providing general medical care through its four medical yard clinics, which handle non-urgent requests for medical services.[11] Patients needing urgent or emergent care are treated in its triage and treatment area (TTA). Additional services are provided in the outpatient housing unit (OHU), through special services, and via telemedicine. VSP provides care to patients in the mental health delivery system at the Enhanced Outpatient Program (EOP) and serves as a reentry hub for incarcerated persons for needs-based rehabilitative services.

In March 2026, the Health Care Services Master Registry showed VSP had a total population of 3,139. A breakdown of the medical risk level of the WSP population as determined by the department is set forth in Table 2 below.[12]

Table 2. VSP Master Registry Data as of March 2026

Medical Risk Level	Number of Patients	Percentage*
High 1	422	13.4%
High 2	546	17.4%
Medium	1,262	40.2%
Low	909	29.0%
Total	**3,139**	**100%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated March 09, 2026.

[11] Institutions designated as "*basic*" are generally expected to have a high-risk medical population of approximately 5%. At over 30%, VSP's high risk population is more than six times the expected ratio. However, this institution is still assigned a medical staffing package consistent with its *basic* designation. This discrepancy between VSP's designation and patient complexity may account in part for some deficiencies we identified. Additionally, in light of this discrepancy, VSP's proficient scores in multiple case review and compliance indicators is highly commendable.

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, VSP had no vacant executive leadership positions, 3.0 primary care provider vacancies, 1.2 nursing supervisor vacancies, and 6.3 nursing staff vacancies.

Table 3. VSP Health Care Staffing Resources as of March 2026

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	11.0	11.2	130.5	157.7
Filled by Civil Service	5.0	8.0	10.0	124.2	147.2
Vacant	0	3.0	1.2	6.3	10.5
Percentage Filled by Civil Service	100%	72.7%	89.3%	95.2%	93.3%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	0	0	0
Percentage Filled by Registry	0	0	0	0	0
Total Filled Positions	5.0	8.0	10.0	124.2	147.2
Total Percentage Filled	100%	72.7%	89.3%	95.2%	93.3%
Appointments in Last 12 Months	0	3.0	2.0	11.0	16.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	0	0	0
Adjusted Total: Filled Positions	5.0	8.0	10.0	124.2	147.2
Adjusted Total: Percentage Filled	100%	72.7%	89.3%	95.2%	93.3%

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 8 medical inspection pre-inspection questionnaire received on March 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 Permanente HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered VSP'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—VSP'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. VSP had a 35 percent influenza immunization rate for adults 18 to 64 years old and 78 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal immunization rate was 95 percent. 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 Medi-Cal programs—Kaiser Permanente — VSP had a 91 percent colorectal cancer screening rate, a rate higher and thus better than California Medi-Cal as well as Kaiser Permanente.

Table 4. VSP Results Compared to State HEDIS Scores

HEDIS Measure	WSP Cycle 8 Results*	California Medi-Cal†	Kaiser Permanente†
Diabetic Population			
Poor HbA1c Control (>9.0%) ‡, §	**6%**	29%	20%
HbA1c Control (<8.0%) ‡	85%	–	–
Blood Pressure Control (<140/90) ‡	94%	–	–
HbA1c Screening	100%	–	–
Eye Exams	70%	–	–
Immunizations			
Influenza - Adults (18–64)	35%	–	–
Influenza - Adults (65+)	78%	–	–
Pneumococcal – Adults (65+)	95%	–	–
Cancer Screening			
Colorectal Cancer Screening	**91%**	40%	79%

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

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

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

Access to Care

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

Access to Care: Case Review Ratings and Results Summary

In this cycle, case review found VSP performed excellently in delivering access to care for its patients. Staff offered outstanding appointment access to clinic and specialized medical housing providers, clinic nurses, and specialty services, as well as follow-up appointments after urgent and emergent care, hospitalizations, and transferring into VSP. After considering all aspects, 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‡
45	5	1

* The OIG reviewed 45 cases.

† Deficiencies occurred in cases 16, 20, and 22.

‡ A significant deficiency occurred in case 22.

Performed Well

OIG clinicians found VSP performed well in the following areas:

- Access to Clinic Providers[13]
- Access to Specialized Medical Housing Providers[14]
- Follow-up After Hospitalizations[15]
- Follow-up After Transferring Into VSP[16]
- Follow-up After Urgent or Emergent Care[17]
- Access to Clinic Nurses[18]
- Access to Specialty Services[19]

Performed Satisfactorily with Opportunities for Improvement

OIG clinicians at VSP performed satisfactorily with opportunities for improvement in the following:

- Follow-up After Specialty Services

  VSP performed acceptably in providers following up with patients after specialty appointments. However, OIG clinicians identified two deficiencies, a minor and a significant deficiency, in the following case:

  - In case 22, the patient was scheduled to follow up with the provider after prostate cancer radiation treatment. However, this provider appointment did not occur because the patient was unavailable due to another scheduled appointment. The patient had missed a prior appointment the previous week due to lockdown in the yard. The first missed appointment was minor, while the second consecutive missed follow-up after radiation treatment was significant.

Performed Poorly, Improvement Needed

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

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[13] A minor deficiency occurred in case 20.

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

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

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

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

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

[19] Two minor deficiencies in access to specialty services occurred in cases 16 and 22.

Clinician On-Site Inspection

VSP operates four main outpatient clinics: buildings A, B, C, and D. Additionally, VSP has a 20-bed outpatient housing unit (OHU). The OHU houses patients who require more medically complex care and assistance with activities of daily living (ADLs). On-site providers deliver care for each clinic and the OHU. All clinics were staffed with registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs). The office technicians (OTs) reported no appointment backlogs for their providers during the OIG review period. However, at the time of our inspection, they reported a minimal backlog but stated all appointments were scheduled and the backlog would be resolved shortly.

The OIG clinicians observed morning huddles in the clinics and OHU. The providers, MAs, medication line LVNs, and custody staff attended the huddles. Morning huddles lasted approximately 30 minutes, and the patient care teams discussed significant patient encounters, including unscheduled TTA medical emergencies, returns from specialty services, and discharges from hospitalizations. The providers and nurses showed detailed understanding of their patients, including those with expiring medications or those requiring durable medical equipment. As an example, in one clinic huddle, a provider discussed a patient with a significant recent diagnosis of cancer and ensured the patient had a close provider follow-up scheduled. The scheduling supervisor reported appointments were rarely rescheduled due to custody concerns and stated custody worked closely with medical staff to ensure appointments were completed timely.

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
(82.1%)

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

Compliance Testing Results

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

- The institution conducted the most recent chronic care appointments for 22 of 25 sampled patients within the specified time frames (MIT 1.001, 88.0%). For two patients, the appointments occurred 170 and 171 days late. For one patient, the record contained no evidence the appointment occurred.

- When new patients arrive at the institution, the patients must either be assessed by a registered nurse (RN) or evaluated by a provider, depending on their clinical risk level. Of the 25 sampled patients, providers maintained their workflows and completed their comprehensive patient appointments for 24 patients referred for provider appointments (MIT 1.002, 96.0%). For one patient, the record contained no evidence the appointment occurred.

- Following the review of the patients' submitted health care services request forms (CDCR Form 7362), RNs demonstrated excellent performance by completing face-to-face appointments within one business day for 27 of 30 sampled patients (MIT 1.004, 90.0%). For one patient, the appointment occurred one day late. For one patient, nursing staff did not document the visit using the required subjective, objective, assessment, and plan (SOAP) note format. For the remaining patient, the record contained no evidence a refusal form was completed during our review period.

- In 11 applicable samples where RNs identified the need for a primary care referral, the providers evaluated 10 patients within the required time frames according to the priority level assigned to their appointment (MIT 1.005, 90.9%). For one patient, the record contained no evidence the appointment occurred during our review period.

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

- The institution implemented a standardized process for acquiring and submitting health care services request forms for all six housing units (MIT 1.101.2, 100%).

- 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 provided the required timely notification of the specialists' recommendations in 30 of 34 applicable sampled patients (MIT 1.008, 88.2%). For one patient, the PCP follow-up appointment after a high-priority specialty service occurred three days late. For one patient, the record contained no evidence the appointment occurred following a high-priority specialty service during our review period. For one patient, the PCP follow-up appointment after a medium-priority specialty service occurred one day late. For the remaining patient, the PCP follow-up appointment after a routine-priority specialty service occurred two days late.

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

- Nursing staff performed poorly in adhering to triage documentation standards; 13 of 30 sampled patients met the full requirements for a completed review upon receipt of the health care services request form (MIT 1.003, 43.3%). For 17 patients, nursing staff failed to accurately complete the request form with their printed or stamped name.

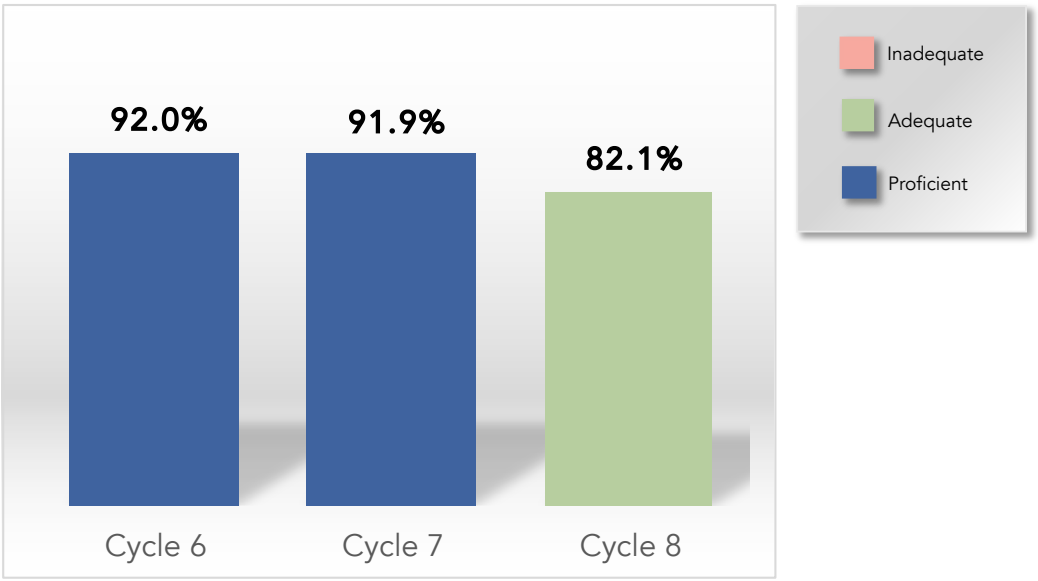
- The institution ensured follow-up provider sick call appointments occurred within the specific time frame ordered by the PCP for one of two applicable sampled patients (MIT 1.006, 50.0%). For one patient, the record contained no evidence the appointment occurred during our review period.

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

- The institution implemented a standardized process for replenishing health care services request forms through which custody officers coordinate with the program office to ensure they maintain an adequate supply for all patients in the housing units (MIT 1.101.1, N/A).

Analysis of Performance Across Inspection Cycles

Figure 1. Access to Care, Compliance Scores Across Cycles



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

VSP met the 75.0 percent passing compliance threshold in this indicator, maintaining a sufficient performance of 82.1 percent in Cycle 8. While this score places VSP's performance well within the ***adequate*** range, this score follows VSP's previous ***proficient*** scores of 92.0 percent in Cycle 6 and 91.9 percent in Cycle 7. The current score represents some regression from previous cycles, indicating the institution's performance is now trending closer to the minimum established standards for **Access to Care**.

Table 6. Access to Care Compliance Test Scores

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	22	3	0	88.0%
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)	24	1	0	96.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	13	17	0	43.3%
Clinical appointments: Did the registered nurse complete a face-to- face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	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)	10	1	19	90.9%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	1	1	28	50.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	23	2	0	92.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? For medium- or routine-priority specialty service appointments: If the patient was not seen, did the PCT inform the patient of the recommendations within the required time frame? (1.008)	30	4	3	88.2%
For informational purposes only: Do custody staff members have a system in place to replenish health care services request forms? (1.101.1)	0	0	6	N/A
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101.2)	6	0	0	100%
			Overall percentage (MIT 1): **82.1%**	

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 request forms (CDCR Forms 7362) and complete all required documentation. Leadership should implement and monitor remedial measures as appropriate.

Diagnostic Services

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

Diagnostic Services: Case Review Ratings and Results Summary

In this cycle, case review found VSP performed satisfactorily with diagnostic services. Compared with Cycle 7, staff showed significant improvement in completing diagnostic tests as staff completed all laboratory tests, radiology studies, and EKGs timely.[20] Additionally, VSP providers promptly received and endorsed diagnostic test results. However, similar to Cycle 7, providers often either did not send or sent incomplete test result notification letters to patients. After considering these findings, 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‡
129	23	0

* The OIG reviewed 129 diagnostic events.

† Deficiencies occurred in cases 1, 2, 5, 7–10, 20–22, and 44. Of these 23 deficiencies, 23 related to health information management and none related to diagnostic test completion.

‡ No significant deficiencies occurred.

Performed Well

OIG clinicians found VSP performed well in the following area:

- Test Completion[21]

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

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

Performed Satisfactorily with Opportunities for Improvement

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

Performed Poorly, Improvement Needed

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

- Health Information Management

  VSP's performance varied in managing diagnostic test results. VSP performed well in forwarding the test results to the providers for review, and the providers almost always endorsed the results timely.[22] However, OIG clinicians identified a pattern of 13 deficiencies related to missing required elements in patient test result notification letters.[23] Providers also did not send letters in nine instances.[24] The following are examples:

  - In case 2, a provider endorsed laboratory test results. However, the provider did not generate a patient test result notification letter.
  - In case 7, a provider sent a patient laboratory test result notification letter. However, the letter did not include whether the results were unchanged, within normal limits, or as expected.
  - In case 20, a provider endorsed an ultrasound test result two days late.

[22] A minor deficiency relating to a late provider endorsement occurred in case 20.

[23] Deficiencies occurred in cases 7–10, 20, 21, and 44.

[24] Deficiencies occurred in cases 1, 2, 5, 7, and 22.

Clinician On-Site Inspection

The OIG clinicians discussed with the chief support executive (CSE) about VSP's diagnostic processes. The CSE reported sufficient staffing with no staff shortages. Five staff laboratory and one senior technologist worked in laboratory services. Radiology services included two radiology and one senior technologist. The CSE stated the nursing staff and providers would order off-site pathology results that were obtained either during hospitalizations or specialists' encounters. Upon receiving the provider order, diagnostics staff would obtain these results, close out any outstanding requisitions, and enter the information into the EHRS.[25] The CSE did not report any problems with obtaining and scanning off-site diagnostic reports including CTs, MRIs, or PET scans.[26]

Photo 2. Laboratory department.
Photographed on 6-16-2026.

Photo 1. X-ray equipment.
Photographed on 6-16-2026.

The on-site radiology technologist performed routine x-ray studies Monday through Friday. VSP also offered CTs, MRIs, FibroScans, and ultrasounds on site.[27] Contracted mobile vendors performed these imaging studies approximately every two weeks. The CSE reported no appointment backlogs with diagnostic tests. VSP providers reported no problems with obtaining laboratory or imaging test results. Although providers seldom ordered STAT laboratory tests, they stated they always received these test results timely.

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

[26] A CT is a computed, or computerized, tomography scan; an MRI is a magnetic resonance imaging scan; and a positron emission tomography (PET) scan is an imaging test using radioactive tracers. All three create detailed images of the organs and tissues to detect diseases and abnormalities.

[27] A FibroScan is a diagnostic imaging scan used to evaluate patients for liver scarring and fatty changes from liver disease.

Case Review Recommendations

- The OIG offers no case review recommendations for this indicator.

Diagnostic Services: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(66.7%)

VSP had 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

VSP 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 nine of 10 sampled patients (MIT 2.002, 90.0%). For one patient, the provider reviewed and endorsed the report one day late.
- Providers demonstrated proficiency in timely reviewing and endorsing laboratory reports for all 10 sampled patients (MIT 2.005, 100%).
- Providers demonstrated proficiency in timely reviewing and endorsing pathology reports for all 10 sampled patients (MIT 2.011, 100%).

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

- Healthcare providers generated patient notification letters for radiology reports with all required elements within specified time frames for five of 10 sampled patients (MIT 2.003, 50.0%). For three patients, although the provider reviewed and endorsed the radiology report, the record contained no evidence the provider generated patient letters at the time of review and endorsement, as required by policy. For two patients, the patient letters were missing key elements as required by policy.
- Laboratory services consistently completed orders for five of 10 sampled patients within the time frames specified (MIT 2.004, 50.0%). For five patients, the laboratory services ordered as timed and routine studies were not performed within the specified time frames.
- Healthcare providers generated patient notification letters for laboratory reports with all required elements within specified time frames for only one of 10 sampled patients (MIT

2.006, 10.0%). For nine patients, the patient letters were not generated at the time of provider's review and endorsement, as required by policy.

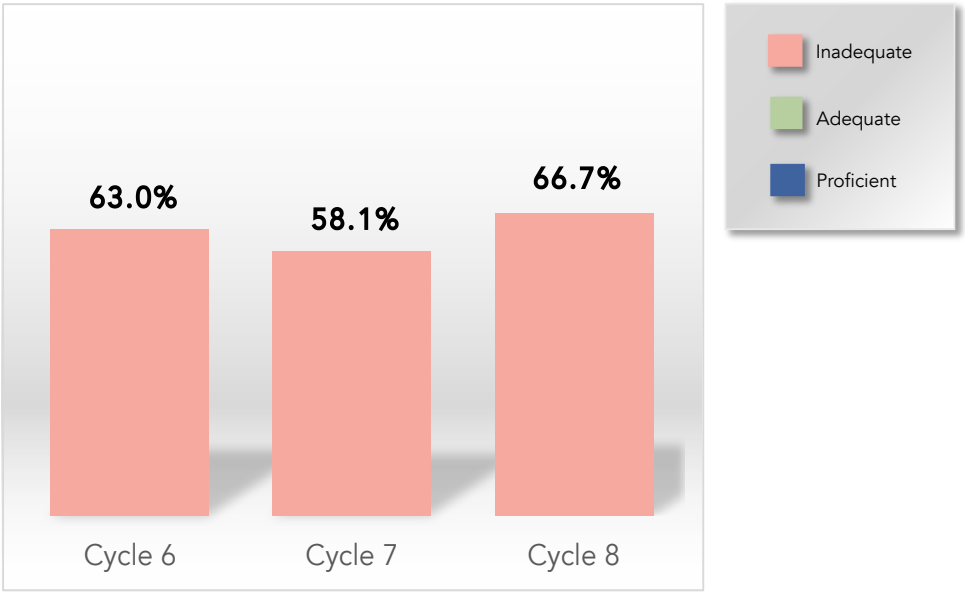
- VSP received pathology reports for seven of 10 sampled patients within required time frames (MIT 2.010, 70.0%). For three patients, the pathology reports were received between 16 and 35 days late.
- Healthcare providers generated a patient notification letter for pathology laboratory results within specified time frames for only three of 10 sampled patients (MIT 2.012, 30.0%). For seven patients, the record contained no evidence of a generated patient letter communicating pathology results during our review period.

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

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

Analysis of Performance Across Inspection Cycles

Figure 2. Diagnostic Services, Compliance Scores Across Cycles



Source: OIG VSP 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 66.7 percent in Cycle 8. While this score remains in the ***inadequate*** performance range, this indicator follows fluctuating ***inadequate*** scores of 63.0 percent in Cycle 6 and a regression to 58.1 percent in Cycle 7. The slight recovery in this cycle indicates VSP has successfully established some improvements in this indicator since the prior cycle; however, the overall performance in this indicator still remains below ***adequate*** levels, highlighting a continuing need for improvement.

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)	9	1	0	90.0%
Radiology: Did the ordering health care provider generate the patient notification letter with all the required elements within the specified time frame? Effective 09/2025: Did the health care provider generate the patient notification letter with all required elements within the specified time frame? (2.003)	5	5	0	50.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	5	5	0	50.0%
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)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider generate the patient notification letter with all required elements within the specified time frame? (2.012)	3	7	0	30.0%
				Overall percentage (MIT 2): **66.7%**

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.

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.

Emergency Services: Case Review Ratings and Results Summary

In this cycle, case review found VSP healthcare and custody staff responded promptly to emergency events throughout the institution, and staff performed good quality CPR. However, we identified nurses needed improvement in nursing assessments, interventions, and documentation during emergency events. We also found clinical reviews were often incomplete. When nursing and medical leadership conducted clinical reviews, they did not always identify the same opportunities for improvement as the OIG clinicians. Factoring all the information, the OIG rated this indicator ***inadequate.***

Case Review Results

Table 9. Case Review Emergency Services Results

Urgent or Emergent Events*	Deficiencies†	Significant Deficiencies‡
36	31	7

* Urgent or emergent events occurred in cases 1–9, 17–20, and 44.

† Deficiencies occurred in cases 2–4, 7, 8, and 17–20.

‡ Significant deficiencies occurred in cases 2, 7, and 8.

Performed Well

OIG clinicians found VSP performed well in the following:

- CPR Quality[28]

Performed Satisfactorily, with Opportunities for Improvement

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

- Emergency Medical Response[29]

  VSP staff responded promptly to medical emergencies. OIG found opportunities for improvement in nursing assessment and interventions. The following is an example:

  - In case 2, nursing staff responded to a medical emergency for a patient with suspected drug overdose. The patient had a severely low oxygen saturation level. The nurse applied oxygen using a non-rebreather mask.[30] However, the nurse did not administer the correct amount of oxygen required for a non-rebreather mask to provide an adequate amount of oxygen. Additionally, the nurse did not assess and did not document the patient's vital signs for 21 minutes.

- Nursing Performance in Documentation[31]

  OIG clinicians found opportunities for improvement in nursing documentation. We identified patterns of incomplete documentation. The following are examples:

  - In case 3, staff responded to a medical emergency for an unresponsive patient. Custody and nursing staff performed CPR, applied an automated external defibrillator (AED), initiated rescue breathing, and administered a dose of Naloxone.[32] However, nursing staff did not document administering the Naloxone on the medication administration record.

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[28] CPR occurred in cases 3, 4, 6, and 8. Deficiencies occurred in case 3, none of which were significant.

[29] Emergency medical response review deficiencies occurred in cases 2–4, 7, and 8. Significant deficiencies occurred in cases 2 and 7.

[30] A non-rebreather mask delivers high concentrations of oxygen and is used when a person can breathe on their own but needs a large amount of oxygen quickly.

[31] Nursing documentation deficiencies occurred in cases 3, 8, 17, and 19, none of which were significant.

[32] An automated external defibrillator (AED) is a portable device that can help restore a normal heart rhythm in a patient with cardiac arrest. Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose. According to the manufacturer, nasal naloxone doses can be safely administered every two to three minutes. CCHCS emergency medical training allows nurses to administer five nasal naloxone doses when an opioid overdose is suspected.

- In case 17, the nurse assessed the patient with complaints of dizziness and high blood pressure. The nurse documented the patient's vital signs were stable, completed an EKG, and consulted the PCP. The nurse educated the patient, and the patient returned to his housing unit. However, the nurse did not document either the time the PCP was consulted or the time the patient discharged from the TTA.

- Provider Performance[33]

  VSP providers generally made accurate diagnoses, documented well, and triaged TTA patients appropriately. However, OIG clinicians identified six minor deficiencies related to emergency care. The following is an example:

  - In case 8, the TTA RN called the provider about a patient with a fast heartbeat, severe back pain, and dizziness. The provider ordered an oral rehydration solution and instructions for the patient to keep hydrated. The provider also documented the patient had sciatica; however, the RN documented the musculoskeletal examination as normal.[34] Furthermore, the provider did not thoroughly assess the patient's back pain or consider other causes for the patient's symptoms, including nephrolithiasis (kidney stone).

Performed Poorly, Improvement Needed

OIG clinicians found VSP performed poorly in the following:

- Nursing Performance in Assessments and Interventions[35]

  VSP showed a pattern of incomplete nursing assessments, incomplete or missing reassessments, and incomplete vital signs. Nursing interventions also exhibited a pattern of inappropriate oxygen delivery methods and not contacting the provider when warranted. The following are examples:

  - In case 2, staff activated a medical alarm for a patient with a suspected overdose, who was participating in the medication assisted treatment (MAT) program.[36] The patient informed the nurse he had smoked "spice."[37] The nurse assessed the patient, notified the nursing supervisor, and discharged the

[33] Six minor deficiencies occurred in cases 2, 8, 18, and 20.

[34] Sciatica refers to symptoms such as pain or numbness radiating from the lower back though the hip into the leg caused by compression of the sciatic nerve.

[35] Nursing performance deficiencies in assessments and intervention occurred in cases 2, 7, 8, 19, and 20. Significant deficiencies occurred in cases 2, 7, 8, and 20.

[36] MAT is the medication-assisted treatment program for substance use disorder.

[37] "Spice" is a chemical designed to mimic THC, the main high-inducing compound of marijuana. However, it is not marijuana. It is a dangerous, unpredictable, and highly potent chemical that can be potentially life threatening.

patient back to his housing unit. However, the TTA nurse did not notify the provider the patient had smoked "spice" before discharging the patient from the TTA.

- In case 7, the nurse assessed the patient with a history of irregular heart rhythm, congestive heart failure, high blood pressure, and high cholesterol levels. The patient complained of chest and left arm pain, had a low oxygen saturation level, and had a high heart rate. The nurse did not document the time the patient arrived in TTA and did not obtain an electrocardiogram (EKG). Additionally, the nurses delayed requesting EMS for 38 minutes. The institution agreed with the deficiency.

- In case 8, custody activated a medical alarm for a patient under the influence. The healthcare first responders arrived at the patient and documented the patient's eyes opened with pain, the patient had no verbal response but exhibited withdrawals from pain, the patient was drowsy, the patient's skin was warm and moist, the patient's heart rhythm was regular, and the pupils were reactive. The first medical responder nurse did not obtain vital signs and did not initiate medical intervention for a patient with no verbal response, eyes only open to pain, and who was drowsy.

- Also in case 8, in the same event, the TTA nurse arrived to the scene and transported the patient to TTA. The nurse assessed the patient and documented the vital signs were stable, and the patient informed the nurse he smoked "spice." The patient refused all treatment in TTA and was discharged back to the housing unit. However, the TTA nurse did not consult with the provider about the patient's use of "spice" before discharging the patient back to the housing unit.

- In case 19, staff activated a medical alarm for a patient with chest pain. Nursing staff assessed the patient, performed vital signs, and transported the patient to TTA. Upon arrival to the TTA, the nurse performed an EKG, assessed the patient, and noted an abscess on the sternum with redness and pain to touch. The patient was taking dual antibiotic therapy for the abscess. The nurse consulted the provider, who ordered the patient to be transferred to a higher level of care via state vehicle. However, the nurse delayed notifying the transportation custody team for transport to higher level of care by 37 minutes. Additionally, the nurse did not measure the wound and did not document the condition of the skin surrounding the wound.

- Emergency Medical Response Review Process[38]

  OIG clinicians found VSP performed clinical reviews on emergency medical responses and unscheduled transports to a higher level of care. We identified a pattern in which the supervising registered nurse (SRN) II completed a clinical review, but the chief medical executive (CME) and chief nurse executive (CNE) did not complete their executive portions of the review. Additionally, VSP did not always identify the same opportunities for improvement as the OIG, including significant deficiencies such as assessment, reassessment of patient symptoms, and nursing interventions in the clinical reviews or in the emergency medical response review committee (EMRRC). The following are examples:

  - In case 2, the required staff performed a clinical review for a patient with a suspected overdose, who received Naloxone, and had a low oxygen saturation level. However, the reviewers did not identify the nurse's omission of the patient's vital signs during the time of 8:19 pm to 8:40 pm.

  - In cases 3, 4, and 8, clinical reviews were completed by the SRN II. However, the CME and CNE did not complete their portion of the clinical review.

  - In case 7, the required staff performed a clinical review. However, the reviewer did not identify the nurses' failures to reassess the patient's heart rate, nausea, and abdominal pain. Additionally, they did not identify delays in administering oxygen and requesting EMS.

  - In case 8, the required staff completed the clinical review for a patient with complaints of left abdominal pain for five days, and fever, chills, and nausea for three days with difficulty urinating and burning when urinating. However, the reviewers did not identify between 6:09 pm and 6:40 pm the nurse documented they were unable to reach the PCP on call by phone and could not leave a message. The reviewer similarly did not identify the nurse delayed activating EMS for 19 minutes when unable to reach the provider. Additionally, the reviewer missed the nurse's failure to assess the patient's last meal and last bowel movement.

[38] Emergency medical response deficiencies occurred in cases 2, 3, 7, 8, and 20. Significant deficiencies occurred in cases 2, 7, 8, and 20.

Clinician On-Site Inspection

During our on-site inspection, we toured the TTA and interviewed the TTA nursing staff. The TTA staffing consisted of two RNs for the morning and evening shifts. The night shift was staffed with three RNs. The TTA RNs responded to all medical emergencies in the facility. In addition, all medication LVNs were the first medical responders on morning and evening shifts on their assigned yards. Patients returning from the hospital and outside specialty appointments were assessed in the TTA. TTA staff informed us they had no issues with supplies, equipment, or pharmacy. Supplies were recently moved to a warehouse located outside the prison. The TTA nursing staff informed us nursing morale and administration had improved and their relationship with custody staff was also improving.

Photo 3. TTA exam room.
Photographed on 6/16/26.

Photo 4. TTA exam room.
Photographed on 6-16-2026.

Case Review Recommendations

- Nursing leadership should develop, implement, and monitor strategies to ensure nurses perform complete assessments, provide appropriate interventions, and thoroughly document their actions during emergency events.
- Healthcare leadership should develop, implement, and monitor strategies to ensure nursing supervisors thoroughly complete the emergency medical response review checklists, and the CNE and CME (or designees) timely and thoroughly complete their secondary reviews, in accordance with CCHCS policy.

Emergency Services: Compliance Ratings and Results Summary

Compliance Rating
INADEQUATE
Compliance Score
(52.2%)

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

Compliance Testing Results

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

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

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

- The Emergency Medical Response Review Committee (EMRRC) reviewed cases in a timely manner and ensured incident packages included all required documents for five of 12 sampled patients (MIT 3.001, 41.7%) primarily due to incomplete checklists and untimely reviews for seven patients.

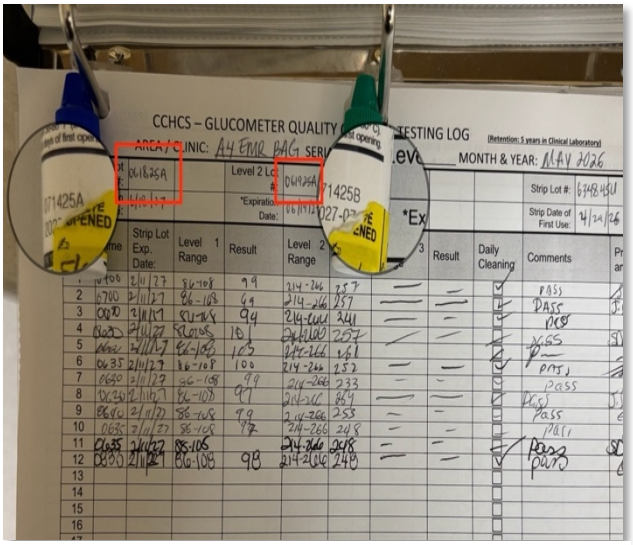


Photo 5. Glucometer daily QC log documentation inaccurate.
Photographed on 5-12-2026.

- Nursing staff inspected and inventoried emergency medical response bags (EMRBs) and ensured they contained all essential items for five of seven applicable clinical areas (MIT 3.101, 71.4%). For two EMRBs, we found one or more of the following deficiencies: staff failed to ensure EMRB compartments were sealed and intact;

and EMRB log and daily glucometer quality control logs were incomplete or inaccurate (see Photo 5, above right).

- Nursing staff failed to inspect and inventory the TTA treatment cart within the required time frame (MIT 3.102, zero). The treatment cart 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 6, right).

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

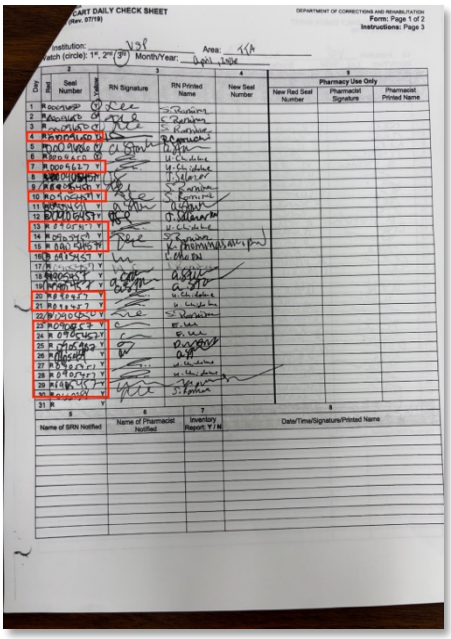
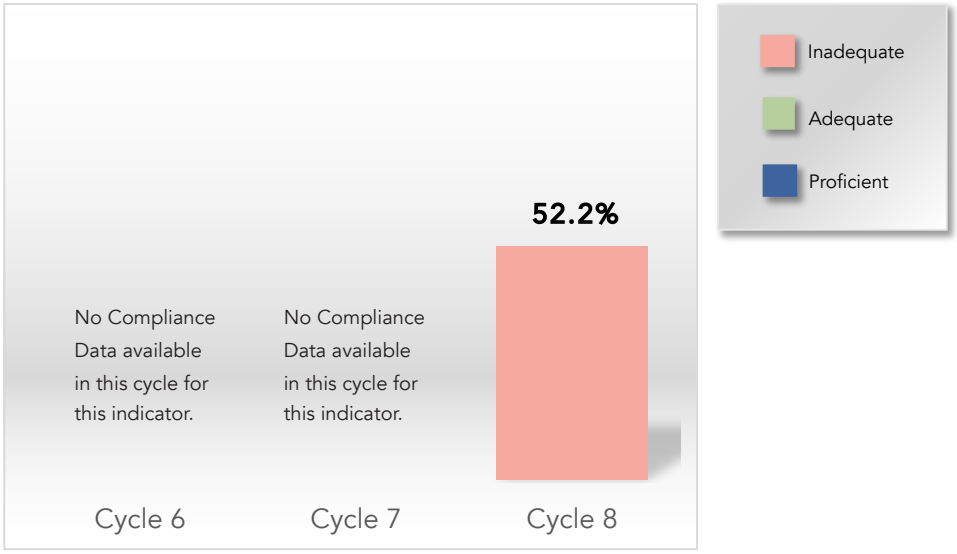

CART DAILY CHECK SHEET

Photo 6. Incomplete treatment cart seal security check log documentation. Photographed on 5-11-2026.

Analysis of Performance Across Inspection Cycles

Figure 3. Emergency Services, Compliance Scores Across Cycles



Source: OIG VSP 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 services readiness and performance evaluation, reaching only 52.2 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 3.101, slight regression from a prior improvement in MIT 3.001, and significant regression in MITs 3.102 and 3.104.

Compliance Score Results

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%

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

Table 11. Emergency Services Compliance Test Scores

	Scored Answer			
Compliance Questions	Yes	No	N/A	Yes %
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the case timely, and did the incident packages reviewed include the required documents? (3.001)	5	7	0	41.7%
Clinical areas: Are emergency medical response bags inspected and inventoried within required timeframes, and do they contain essential items? (3.101)	5	2	2	71.4%
Clinical areas: Are treatment carts inspected and inventoried within required timeframes? (3.102)	0	1	8	0
Clinical areas: Are disaster response bags inspected and inventoried within required timeframes? (3.103)	1	0	8	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did the health care and custody staff participate in those drills? (3.104)	0	3	0	0
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advance Cardiac Life Support (ACLS) certifications? (3.105)	2	0	1	100%
Overall percentage (MIT 3): **52.2%**				

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 and their treatment cart 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 VSP managed health information well. Staff retrieved, scanned, and endorsed hospital and specialty reports timely. They also managed urgent and emergent records appropriately. Providers usually endorsed diagnostic reports timely. However, we identified patterns of providers not sending test result notification letters or sending incomplete letters to the patients. After considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Case Review Results

Table 12. Case Review HIM Results

Events*	Deficiencies†	Significant Deficiencies‡
750	28	0

* The OIG reviewed 750 events.

† Deficiencies occurred in cases 1, 2, 5, 7–10, 20–22, and 44.

‡ No significant deficiencies occurred.

Performed Well

OIG clinicians found VSP performed well in the following areas:

- Hospital Reports[39]
- Specialty Reports[40]
- Urgent and Emergent Records[41]
- Scanning Performance[42]

Performed Satisfactorily, with Opportunities for Improvement

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

Performed Poorly, Improvement Needed

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

- Diagnostic Reports

  VSP performed variably in this sub-indicator. Although providers almost always endorsed patient test results timely, OIG clinicians identified 22 deficiencies related to patient test result notification letters, 13 of which related to incomplete patient notification letters and nine to missing patient notification letters.[43] The following are examples:

  - In case 1, a provider endorsed laboratory test results. However, the provider did not generate a patient test result notification letter.
  - In case 10, a provider sent a patient laboratory test result notification letter. However, the letter did not include whether the results were unchanged, within normal limits, or as expected.

[39] One minor deficiency occurred in case 20.

[40] Four minor deficiencies occurred in cases 7 and 22.

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

[42] Three minor scanning deficiencies occurred in cases 1 and 3.

[43] Missing notification letter deficiencies occurred in cases 1, 2, 5, 7, and 22. Deficiencies relating to incomplete patient notification letters occurred in cases 7–10, 20, 21, and 44. One late provider endorsement occurred in case 20. None of these deficiencies were significant.

Clinician On-Site Inspection

We discussed health information management (HIM) with the CSE. The CSE stated VSP was fully staffed with no recent retirements or vacancies. They reported staff utilized a detailed tracking system to follow up on any missing documents. The CSE explained the close collaboration between the specialty and utilization management nurses ensured timely retrieval of hospital records and specialty reports. After receipt of these documents, HIM staff would then scan them into the EHRS and forward them to the providers for review and endorsement.

HIM supervisors regularly completed audits and sent them to medical leadership for assessing provider report endorsement. HIM staff perform random audits to ensure timely provider review. They also reported an improvement in providers generating complete patient notification letters to include all four components as required by CCHCS policy.

Photo 7. Documents pending scanning in the HIM department.
Photographed on 6-16-2026.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

HIM: Compliance Ratings and Results Summary

In this indicator, VSP 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.***

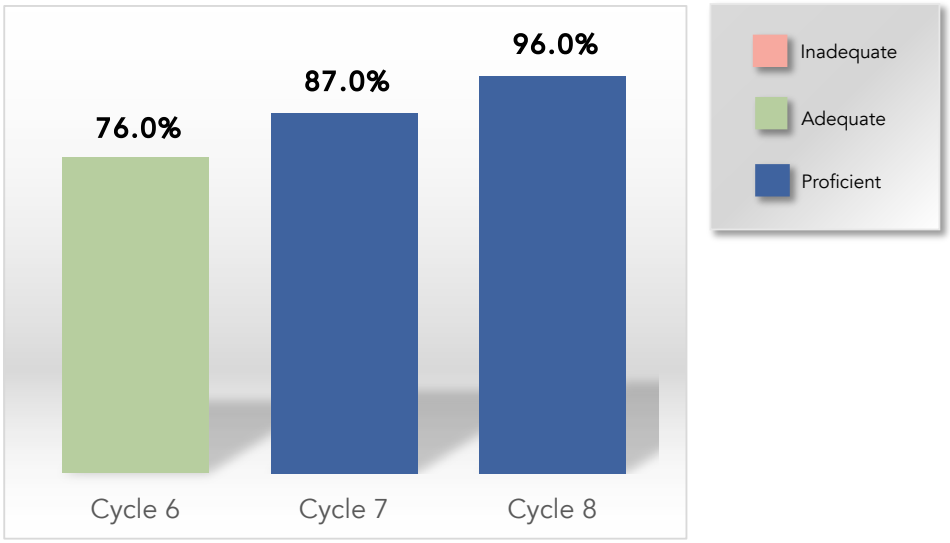
Compliance Testing Results

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

- The institution achieved a perfect compliance score for the timely integration of health care services request forms (CDCR Form 7362) into the electronic health record system (EHRS). Staff scanned all documented forms within the required time frames, ensuring immediate data availability for the patient care team (MIT 4.001, 100%).
- The institution ensured staff scanned specialty notes into patients EHRS in accordance with established timelines for 23 of 25 applicable sampled patients (MIT 4.002, 92.0%). For two patients, staff scanned the specialty reports between one and 13 days late.
- The institution demonstrated exceptional operational performance ensuring community hospital discharge documents were scanned into patient EHRS within required time frames for all 20 applicable sampled patients (MIT 4.003, 100%).
- The institution labeled and scanned records into patient EHRS for 22 of 25 patients (MIT 4.004, 88.0%). For three patients, the documents were mislabeled.
- The institution exhibited proficiency ensuring the provider reviewed and endorsed community hospital discharge reports within five calendar days of discharge for all 25 sampled patients (MIT 4.005, 100%).

Analysis of Performance Across Inspection Cycles

Figure 4. Health Information Management, Compliance Scores Across Cycles



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

In Cycle 8, VSP's performance exceeded the 75.0 percent passing compliance threshold for health information management (HIM), reaching 96.0 percent in Cycle 8. This score follows the ***adequate*** performance result of 76.0 percent in Cycle 6 and the lower ***proficient*** performance result of 87.0 percent in Cycle 7. The current score represents a continuous, steady improvement over the past three cycles, indicating the institution's successful commitment to achieving peak performance in this indicator.

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)	23	2	12	92.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	20	0	5	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	22	3	0	88.0%
For patients discharged from a community hospital: Did a provider review and endorse the report within five calendar days of discharge? (4.005)	25	0	0	100%
Overall percentage (MIT 4): **96.0%**				

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.

Health Care Environment

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

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

Health Care Environment: Compliance Ratings and Results Summary

Compliance Rating
PROFICIENT
Compliance Score
(85.0%)

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

Compliance Testing Results

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

- The institution demonstrated very good performance in maintaining a clean and sanitary environment for eight of nine applicable clinical health care areas (MIT 5.101.2, 88.9%). In one location, the cabinet in the clinical area was found unclean (see Photo 8, right).

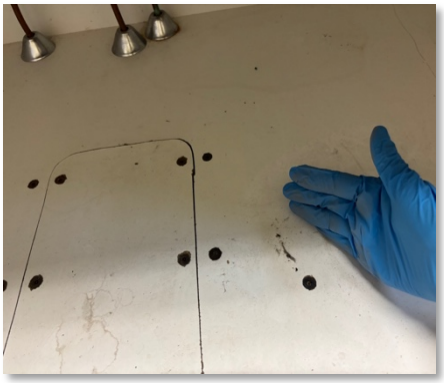


Photo 8. Unclean cabinet under the sink. Photographed on 5-12-2026.

- The institution demonstrated excellent performance in ensuring staff consistently updated the corresponding cleaning logs for eight of nine clinics (MIT 5.101.3, 88.9%). For one clinic, the cleaning log was incomplete and missing inmate-porter initials.

- All nine clinics ensured clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies (MIT 5.103, 100%).

- The institution attained perfect performance in ensuring clinical health care areas controlled exposure to blood-borne pathogens and contaminated waste for all nine applicable clinics (MIT 5.105, 100%).

- The institution's medical warehouse delivered exceptional performance in ensuring the medical supply management process adequately supported the needs of the medical health care program (MIT 5.106, 100%).

- The institution sustained outstanding performance in ensuring the environments in the common clinical areas for all eight applicable clinics and the nonclinical areas for all nine clinics were conducive to providing medical services (MIT 5.109.1, 100% and MIT 5.109.2, 100%).

- The institution upheld superior performance in ensuring the clinic examination rooms had adequate space and remained free of clutter to provide medical services for all seven applicable clinics (MIT 5.110.1, 100% and MIT 5.110.2, 100%). Furthermore, all seven clinic examination rooms were equipped with working computer stations, well-maintained furniture, and accessible medical equipment (MIT 5.110.3, 100%).

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

- Six of eight medical staff observed adhered to universal hand hygiene precautions, in which staff members followed proper handwashing protocols (MIT 5.104, 75.0%). In two clinics, clinicians did not wash or sanitize their hands before and after physically touching the patient, or before subsequent regloving.

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

- The institution ensured reusable non-invasive medical equipment was properly disinfected as warranted for only two of four applicable clinical health care areas (MIT 5.102.2, 50.0%). For one clinic, the health care staff failed to remove examination table paper after conducting a patient encounter. For the remaining clinic, the health care staff failed to use examination table paper during a patient encounter.

- Five of nine clinics ensured adequate management and storage of bulk medical supplies (MIT 5.107, 55.6%). Specific deficiencies for four clinics included disorganized medical supplies, and storage of supplies beyond the manufacturer's guidelines (see Photos 9 and 10, right).

Photo 9. Expired medical supplies.
Photographed on 5/11/2026.

Photo 10. Expired medical supplies.
Photographed on 5/12/2026.

- Six of nine clinics ensured common areas and examination rooms were equipped with essential core medical equipment and supplies (MIT 5.108.2, 66.7%). In three clinics, we found one or more of the following deficiencies: staff did not consistently conduct daily performance checks of the automated external defibrillator (AED); a defibrillator test performance was found incomplete; the Snellen eye examination chart was missing a clear demarcation line; and a glucometer quality control log was incomplete.

- Four of seven applicable clinics ensured examination rooms allowed for privacy and confidentiality when providing medical services (MIT 5.110.4, 57.1%). In three clinics, the confidential medical records were kept visible, unsecured, and easily accessible to unauthorized persons (see Photo 11, right).

Photo 11. Confidential records visible and easily accessible.
Photographed on 5/12/2026.

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). In the yard clinics, VSP clinical staff expressed no 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. However, in the TTA, health care staff did express concerns that the CALCTRA and Healthcare Facilities Maintenance (HFM) used unclean and "musky" rags when cleaning surface areas, which left a moldy smell in the areas after cleaning.

- 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).

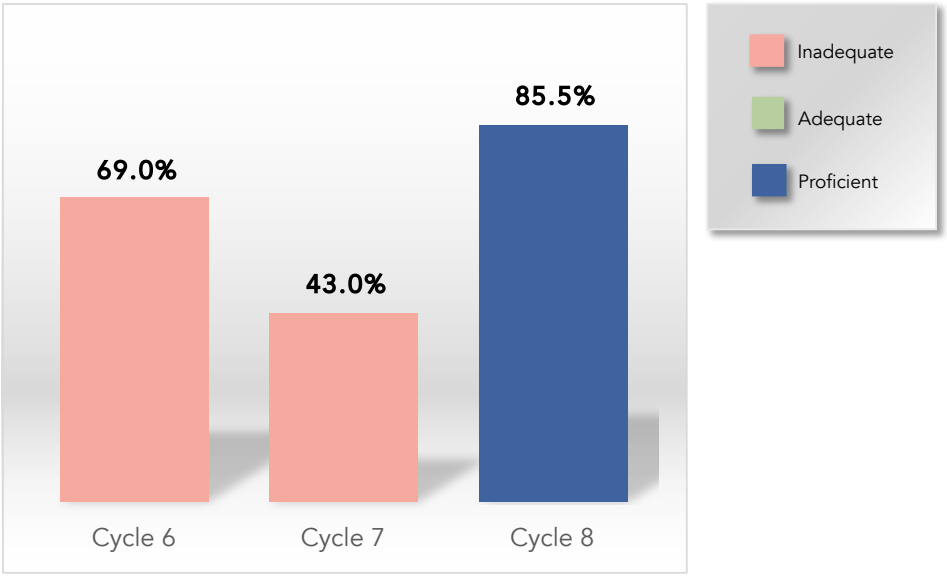
- We inspected indoor and outdoor patient waiting areas. Health care and custody staff reported existing waiting areas had sufficient seating capacity (see Photo 12, right). During our inspection, we did not observe overcrowding in any of the clinics' indoor and outdoor waiting areas (MIT 5.109.2, N/A).

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

Photo 12. Sufficient patient waiting area. Photographed on 5-11-2026.

Analysis of Performance Across Inspection Cycles

Figure 5. Health Care Environment, Compliance Scores Across Cycles



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

In Cycle 8, VSP performed above established standards for health care environment, successfully exceeding the requirements for this cycle. The institution surpassed the 75.0 percent passing compliance threshold for health care environment, reaching a ***proficient*** score of 85.5 percent in Cycle 8. This rating demonstrates a substantial recovery following an ***inadequate*** rating of 69.0 percent in Cycle 6 and a subsequent lower ***inadequate*** rating of 43.0 percent in Cycle 7. This remarkable recovery indicates an outstanding commitment to improvement in this indicator.

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	9	N/A
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101.2)	8	1	0	88.9%
Infection control: Are clinical health care areas completing and maintaining cleaning logs for all clinical areas and implementing cleaning protocols during modified programming? (5.101.3)	8	1	0	88.9%
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	9	N/A
Infection control: Do clinical health care areas ensure that reusable non-invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.2)	2	2	5	50.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	9	0	0	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	6	2	1	75.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	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	4	0	55.6%
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	9	N/A
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108.2)	6	3	0	66.7%
Clinical areas: Are the environments in the common clinical areas conducive to providing medical services? (5.109.1)	8	0	1	100%
Clinical areas: Are the environments in the common non-clinical areas conducive to providing medical services? (5.109.2)	9	0	0	100%
Clinical areas: Do the clinic exam rooms have adequate space to provide medical services? (5.110.1)	7	0	2	100%
Clinical areas: Are the clinic exam rooms free of clutter and conducive to providing medical services? (5.110.2)	7	0	2	100%
Clinical areas: Do clinic exam rooms have working computer stations and well-maintained furniture and accessible medical equipment? (5.110.3)	7	0	2	100%
Clinical areas: Do clinic exam rooms allow for privacy and confidentiality when providing medical services? (5.110.4)	4	3	2	57.1%
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): **85.5%**

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.

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 Valley State Prison performed sufficiently in the transfer process. When patients arrived at VSP, nurses performed well and provided good assessments and initiated required appointments. However, when patients transferred from VSP, occasionally nurses did not document thoroughly and did not ensure patients had necessary medications. Additionally, we found, when patients returned from a community emergency room, patients almost always received medications timely, and nurses always assessed their patients; however, sometimes the nurses' assessments were incomplete. Additionally, on a couple occasions, providers did not thoroughly review their patients' hospital records. Considering all factors, the OIG rated the case review component of this indicator rating ***adequate***.

Case Review Results

Table 15. Case Review Transfers Results

Transfer Events*	Deficiencies†	Significant Deficiencies‡
34	14	4

* The OIG clinicians reviewed 34 events in 17 cases in which patients transferred into or out of the institution including 14 events in which patients returned from an off-site hospital or emergency room.

† Deficiencies occurred in cases 1, 7, 8, 19, 20, 24, 26–28, and 44.

‡ Significant deficiencies occurred in cases 1, 7, 8, and 19.

Performed Well

OIG clinicians found VSP performed well in the following:

- Transfers In[44]

  OIG clinicians found nurses screened patients appropriately and requested provider appointments within the required time frame.

Performed Satisfactorily with Opportunities for Improvement

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

- Transfers Out[45]

  OIG clinicians found nurses screened patients appropriately and ensured all patients had their medical equipment. However, we found, on a few occasions, nurses did not ensure the patients had their rescue or transfer medications. We also found nurses occasionally did not document all transfer information. The following are examples:

  - In case 8, a nurse completed a pre-boarding transfer screening for a patient transferring to another institution for a mental health crisis. The nurse documented, "unable to locate transfer packet that was prepared from prior shift with transfer meds" and noted the patient was missing medications. The

[44] OIG clinicians reviewed nine transfers-in events in cases 6, 8, and 23–25. Deficiencies occurred in cases 8 and 24, none of which was significant.

[45] OIG clinicians reviewed seven transfers out events in cases 8 and 26–28. Deficiencies occurred in each of these cases, none of which was significant.

nurse did not prepare and ensure a transfer packet and medications were sent with the patient.

- In case 27, the nurse did not ensure the patient had a prescribed rescue medication, nitroglycerin. The nurse also did not document the patient had a pending cardiology specialist appointment.

- Hospital Returns[46]

  OIG clinicians found patients returning from the community hospital almost always received their medications without interruption. We also found nurses always assessed patients upon their return from community hospitals and emergency rooms; however, nurses intermittently did not perform complete assessments. We also identified a couple occasions when VSP providers did not thoroughly review their patient's hospital records. The following are examples, which show opportunities for improvement:

  - In case 7, a patient returned to VSP after a community hospital admission for multiple chronic conditions, including congestive heart failure; however, the nurse did not listen to the patient's lungs sounds and did not assess for edema.[47]

  - In case 8, a VSP provider reviewed the community hospital discharge records for a patient but did not recognize the hospital provider did not address the patient's positive blood cultures. Additionally, the VSP provider also did not address the positive blood cultures.[48]

Performed Poorly, Improvement Needed

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

[46] OIG clinicians reviewed 14 hospital return events in cases 1, 2, 7, 8, 18, 19, 20, and 44. Deficiencies occurred in cases 1, 7, 8, 19, 20, and 44. Significant deficiencies occurred in cases 1, 7, 8, and 19.

[47] Congestive heart failure (CHF) means the heart is not pumping blood throughout the body as efficiently as it should. Depending on the severity of CHF, this can cause a back-up of fluid. The fluid can build up in the lung, legs, ankles, feet, or abdomen. Because the heart is not pumping efficiently, the body also does not receive as much oxygen-rich blood, which can cause weakness, fatigue, and difficulty breathing.

[48] A blood culture tests a patient's blood for harmful germs like bacteria or fungi that can cause serious infections.

Clinician On-Site Inspection

We inspected the receiving and release (R&R) area and interviewed the R&R RN. The R&R RN was knowledgeable about the transfer processes and shared one RN was staffed on each shift. According to the RN, when extra support was needed, nursing staff was available to help. The RN also indicated R&R had licensed correctional clinic (LCC) medications available and an Omnicell which held narcotics.[49] The nurse did not report any issues with supplies, equipment, or pharmacy and reported communicating well with custody staff, noting no major challenges. Normally, an average of 10 patients would arrive to VSP, and 15 patients transferred out each week. However, we learned VSP recently experienced an increase in new arrivals. Instead of 10 patients arriving each week, they were now receiving an average of 35 patients per week. This increase was due to the A yard accepting enhanced outpatient program (EOP) patients.[50]

Photo 13. R&R holding area.
Photographed on 6/17/26.

Photo 14. R&R RN exam room.
Photographed on 6/17/26.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure nurses document pending specialty referrals for patients transferring to other institutions and ensure nurses verify patients have rescue medications on their person prior to transfer. Leadership should implement and monitor remedial measures as appropriate.

- Medical leadership should ensure providers thoroughly review their patients' community hospital and emergency room records and should implement and monitor remedial measures as appropriate.

[49] The licensed correctional clinic (LCC) stock medications are those provided by the pharmacy for the medical staff to administer that are not patient specific. An Omnicell is an automated medication dispensing machine.

[50] EOP is the enhanced outpatient program, a mental health program.

Transfers: Compliance Rating and Results Summary

Compliance Rating
PROFICIENT
Compliance Score
(86.9%)

VSP's performance reflects very good adherence to requirements in this indicator for this cycle. Based on the overall compliance score result of 86.9 percent, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Testing Results

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

- Nursing staff completed initial health screenings and answering all screening questions within the required time frame for 23 of 25 sampled patients (MIT 6.001, 92.0%). For two patients, nursing staff failed to document weight measurements during screening process.

- Nursing staff showed sufficient performance in completing the assessment and disposition sections of the initial health screening form for 23 of 25 sampled patients (MIT 6.002, 92.0%). For two patients, the registered nurse (RN) did not thoroughly complete the assessment and disposition of the initial health screening forms.

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

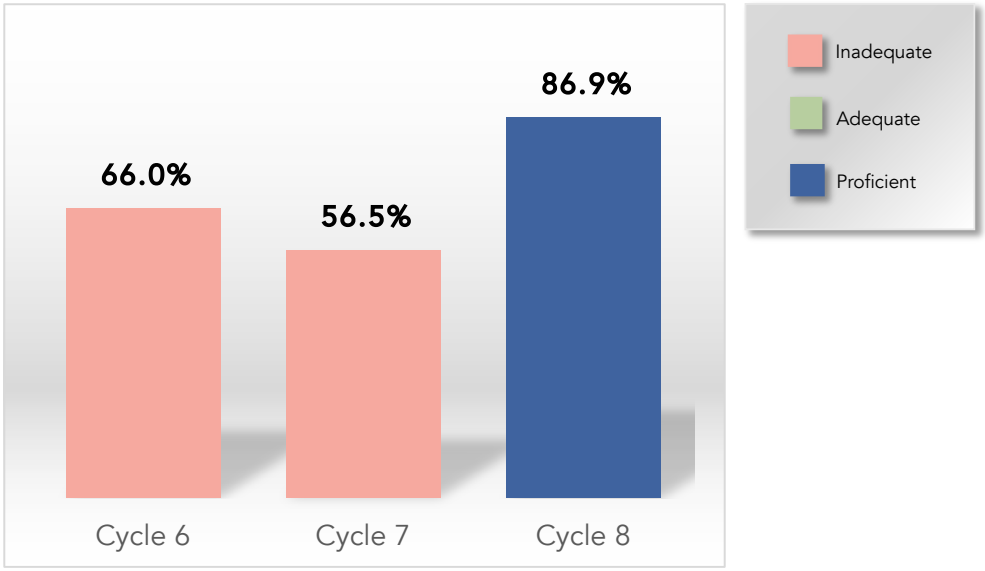
- Nursing staff ensured medications were administered or delivered without interruption for 14 of 22 applicable sampled patients (MIT 6.003, 63.6%). For eight patients, we found one or both of the following deficiencies: incomplete documentation of the patient's stated reason for refusing medication, or the record contained no evidence of the 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 included all required durable medical equipment along with ensuring the corresponding transfer packet required documents for all three sampled patients (MIT 6.101, 100%).

Analysis of Performance Across Inspection Cycles

Figure 6. Transfers, Compliance Scores Across Cycles



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

In Cycle 8, VSP performed well above established standards for Transfers, successfully meeting the requirements for this cycle. The institution exceeded the 75.0 percent passing compliance threshold for this indicator, reaching 86.9 percent in Cycle 8. This score follows a previous ***inadequate*** performance result of 66.0 percent in Cycle 6 and a subsequent decreased ***inadequate*** score of 56.5 percent in Cycle 7. The current Cycle 8 score has significantly increased into the ***proficient*** range, indicating the institution's performance has undergone substantial improvements and is now trending well above the minimum established standards for Transfers.

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)	23	2	0	92.0%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	23	2	0	92.0%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or issued without interruption? (6.003)	14	8	3	63.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	3	0	0	100%
Overall percentage (MIT 6): **86.9%**				

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

Compliance Recommendations

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

Medication Management

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

Medication Management: Case Review Ratings and Results Summary

In this cycle, case review found VSP's overall performance in medication management was very good. Our clinicians found the institution performed exceptionally in medication continuity for patients on chronic care medications, patients returning from the hospital, patients transferring in and out of the institution, and patients in specialized medical housing. However, we found an opportunity for improvement in administering newly prescribed medications without interruption. Considering all factors, OIG rated the case review component of this indicator ***proficient***.

Case Review Results

Table 17. Case Review Medication Management results

Medication Events*	Deficiencies†	Significant Deficiencies‡
134	8	3

* The OIG clinicians reviewed 134 events in 28 cases related to medications.
† Deficiencies occurred in cases 1, 7, 8, 16, 17, 19, and 44.
‡ Significant deficiencies occurred in cases 1, 7, and 16.

Performed Well

OIG clinicians found VSP performed well in the following:

- Chronic Medication Continuity[51]
- Hospital Discharge Medications[52]
- Specialized Medical Housing Medications[53]
- Transfers Medications[54]

Performed Satisfactorily, with Opportunities for Improvement

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

- Newly Prescribed Medications[55]

  The institution overall performed well with ensuring availability, administration, and delivery of newly prescribed medications within the required time frame. However, we identified significant lapses in medication continuity in two cases:

  - In case 1, the patient returned from a community hospital admission for an acute stroke and coronary artery occlusion.[56] The patient received two newly prescribed blood thinner medications two days late.
  - In case 16, the provider ordered a new keep on person (KOP) cholesterol-lowering medication, atorvastatin, to start in December 2025.[57] However, the patient received the medication one month later.

Performed Poorly, Improvement Needed

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

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[51] Chronic care medication deficiencies occurred in cases 7, 16, and 17. A significant deficiency occurred in case 7.

[52] Hospital discharge medication deficiencies occurred in cases 1 and 44. A significant deficiency occurred in case 1.

[53] Specialized medical housing had no medication deficiencies.

[54] One transfer medication deficiency occurred in case 8, which was not significant.

[55] Newly prescribed medication deficiencies occurred in cases 1, 16, 19, and 44. Significant deficiencies occurred in cases 1 and 16.

[56] Coronary artery occlusion is a complete blockage of the heart artery, which instantly stops blood flow in the coronary artery and which can cause death.

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

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians interviewed the medication administration nurses in B and C yards. B and C yards are staffed with four LVNs on the morning shift and three LVNs on the evening shift. The medication LVNs attend clinic huddles daily and discuss patient medication concerns at that time. In addition to medication administration, other LVN duties include responding to medical emergencies in their assigned yards.

Photo 15. Medication Distribution Room. Photographed on 6-16-26.

The staff did not report any issues with supplies, equipment, or pharmacy. The medication nurses were knowledgeable regarding the KOP medication process and the process for patients transferring from yard to yard or to another institution. The medication LVNs reported they generally had a good relationship with custody staff, nursing morale was fair, and their supervisors and chief nurse executive (CNE) were helpful and receptive.

Photo 16. Pharmacy Room. Photographed on 6-16-26.

The CNE discussed patients could receive medication from any medication window on the yard. This process was implemented to decrease wait times at the medication windows to less than 30 minutes. The CNE reported this process was working well for yards B, C, and D.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

Medication Management: Compliance Ratings and Results Summary

Compliance Rating

INADEQUATE

Compliance Score

(60.7%)

VSP's performance needed improvement in this indicator. Based on the overall compliance score result of 60.7 percent, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

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

- The institution showed proficiency in making newly ordered prescription medications available to patients within the required time frames for 18 of 21 applicable sampled patients (MIT 7.002.1, 85.7%). For three patients, the pharmacy did not make newly ordered medications available to the patient within the required time frame.
- The institution administered or issued newly ordered prescription medications within required time frames for 20 of 23 applicable sampled patients (MIT 7.002.2, 87.0%). For three patients, we found one or both of the following deficiencies: nursing staff failed to deliver medication to the patient by the ordering provider's administration date, or KOP medications were not issued within policy time frames.
- The provider ordered post-hospitalization medication orders within the required time frames for all 25 sampled patients (MIT 7.003.1, 100%).
- The institution adequately stored and secured narcotic medications for all nine applicable clinic and medication line locations (MIT 7.101, 100%).
- Staff successfully stored valid, unexpired medications in all 10 medication line locations (MIT 7.104, 100%).
- Staff in all six applicable medication preparation and administration areas showed appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 100%).
- VSP properly stored nonrefrigerated medication in the pharmacy location (MIT 7.109, 100%).

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

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

- Only six of 23 applicable patient samples received chronic care medications within required time frames (MIT 7.001, 26.1%). In 17 patients, we found one or more of the following deficiencies: chronic care medications were not timely made available to the patients; the record contained no evidence the patient either refused or received their chronic care medications; staff did not document the patient's stated reason for refusing medication; or KOP medications were not issued within policy time frames.

- The institution's pharmacy made available post-hospitalization medication orders within the required time frames for 12 of 25 sampled patients (MIT 7.003.2, 48.0%). For 13 patients, the pharmacy was not timely in filling and dispensing medications as ordered.

- The institution administered or issued post-hospitalization medication orders within the required time frames for 10 of 25 sampled patients (MIT 7.003.3, 40.0%). For 15 patients, we found one or more of the following deficiencies: staff did not document the patient's stated reason for refusing medication; nursing staff failed to deliver medication to the patient by the ordering provider's administration date; or staff did not issue KOP medications within policy time frames.

- The institution administered or delivered medications without interruption for patients transferring within the institution for 15 of 25 patients (MIT 7.005, 60.0%). For 10 patients, we found one or both of the following deficiencies: nursing staff failed to completely document the patient's stated reasons for refusing medication, 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 VSP for five of 10 sampled patients (MIT 7.006, 50.0%). For two patients, nursing staff failed to completely document the patient's stated reason for refusing medications.

- VSP appropriately stored and secured non-narcotic medications in five of 10 clinic and medication line locations (MIT 7.102, 50.0%). In five locations, we found one or both of the following deficiencies: nurses did not maintain unissued medication in its original labeled packing (see Photo 17, right); or the medication area lacked a clearly labeled designated area for refrigerated medications to be returned to the pharmacy.

Photo 17. Nurses did not maintain unissued medication in original labeled packing.
Photographed on 5-12-2026.

- Staff kept medications protected from physical, chemical, and temperature contamination in five of 10 clinic and medication line locations (MIT 7.103, 50.0%). In five locations, we found one or more of the following deficiencies: medications were stored in the same area with germicides; medication refrigerators were unsanitary (see Photo 18, below left); or staff did not store oral and topical medications separately.

Photo 18. Medication refrigerator found unsanitary.
Photographed on 5-12-2026.

- Nurses exercised proper hand hygiene and contamination control protocols in three of six applicable locations (MIT 7.105, 50.0%). In three locations, some nurses neglected to wash or sanitize hands when required. These occurrences included before preparing and administering medications, or before each subsequent re-gloving.

- Staff in four of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 66.7%). In two locations, medication nurses did not always ensure patients swallowed direct observed therapy (DOT) medications.

- VSP pharmacy followed organization and cleanliness management protocols in its main pharmacy; however, it failed to follow general security for its main pharmacy (see Photo 19, below left) (MIT 7.108, zero).

Photo 19. Main pharmacy door found unsecured and unlocked.
Photographed on 5-13-2026.

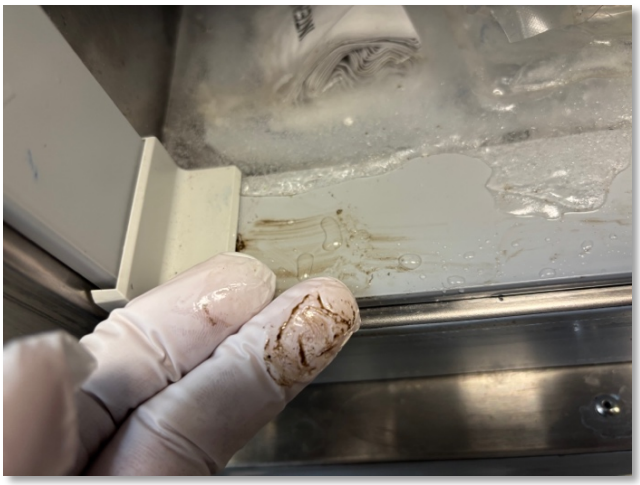


Photo 20. Pharmacy medication freezer found unsanitary.
Photographed on 5-12-2026.

- The institution did not properly store refrigerated or frozen medications in its main pharmacy (MIT 7.110, zero). Specifically, the pharmacy medication refrigerator and freezer were found unsanitary (see Photo 20, above right).

- We examined five medication error reports. The PIC did not timely and correctly process any of the five reports (MIT 7.112, zero). For five reports, we found one or more of the following deficiencies: the medication error follow-up forms were not timely initiated within the specified time frames; the record contained no evidence the prescriber or the patient were notified of the medication error; or the record contained no evidence the PIC recommended changes to prevent the medication error from occurring in the future.

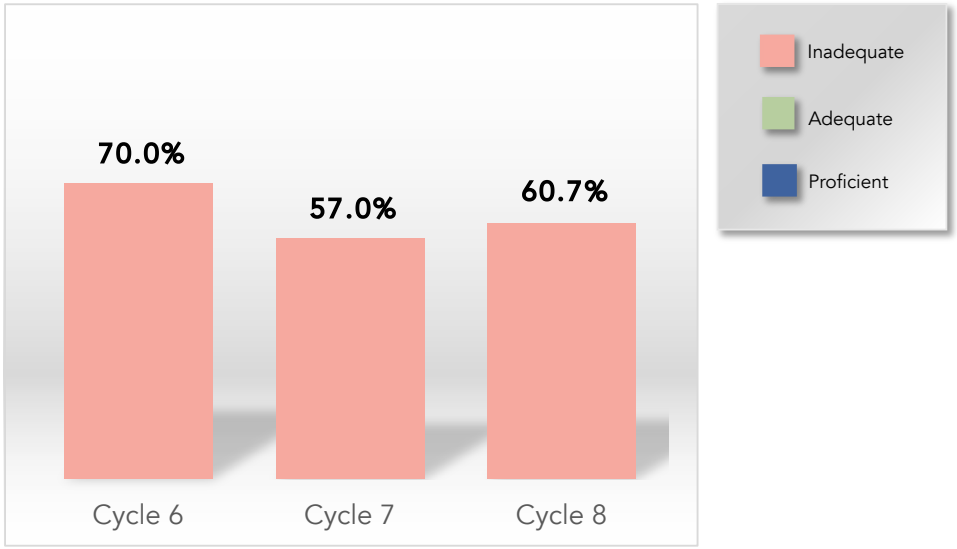
The following test(s) are not scored, but are reported for informational purposes:

- In addition to testing the institution's self-reported medication errors, our inspectors also followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At VSP, 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 medications. Six of seven applicable patients interviewed indicated they had access to their rescue medications. One patient did not have their rescue medications on person. We promptly notified the CEO of this concern, and the clinical staff met with the patient and PCP, and all agreed to discontinue the rescue medication (MIT 7.999, N/A).

Analysis of Performance Across Inspection Cycles

Figure 7. Medication Management, Compliance Scores Across Cycles



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

In Cycle 8, VSP performed below established standards for medication management. The institution did not meet the 75.0 percent passing compliance threshold for this indicator, attaining only 60.7 percent in Cycle 8. This score follows a previous higher ***inadequate*** performance result of 70.0 percent in Cycle 6 then a lower ***inadequate*** performance result of 57.0 percent in Cycle 7. While VSP's performance has shown a slight increase from Cycle 7, the overall performance in this indicator still remains significantly below ***adequate*** levels, highlighting a continuing need for improvement.

Compliance Score Results

Table 18. Medication Management Compliance Test Scores

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	6	17	2	26.1%
Did health care staff make available, new order prescription medications to the patient within the required time frames? (7.002.1)	18	3	4	85.7%
Did health care staff administer or issued new order prescription medications to the patient within the required time frames? (7.002.2)	20	3	2	87.0%
Upon the patient's discharge from a community hospital: Did the provider order the medications within required time frames? (7.003.1)	25	0	0	100%
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)	12	13	0	48.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administer or issued to the patient within required time frames? (7.003.3)	10	15	0	40.0%
For patients received from a county jail: Did the provider order the medications within required time frames? (7.004.1)	N/A	N/A	N/A	N/A
For patients received from a county jail: Were all medications made available to the patient within the required time frames? (7.004.2)	N/A	N/A	N/A	N/A
For patients received from a county jail: Were all ordered medications administer or issued to the patient within required time frames? (7.004.3)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	15	10	0	60.0%
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	5	0	50.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	9	0	1	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	5	5	0	50.0%
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)	5	5	0	50.0%
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)	10	0	0	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	3	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	0	4	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	4	2	4	66.7%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	0	1	0	0

Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
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)	0	5	0	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): **60.7%**

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. 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

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

Compliance Testing Results

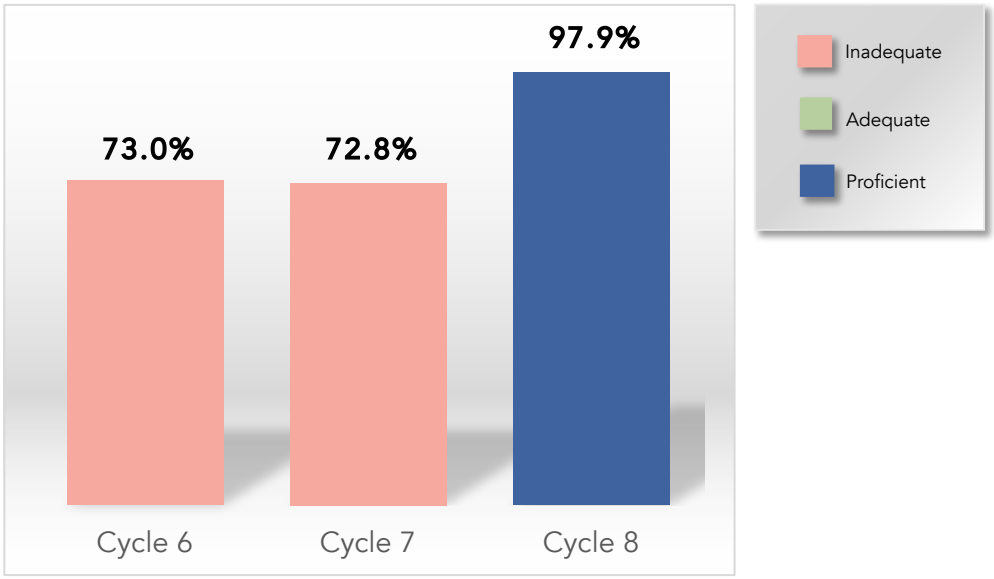
VSP performed in the ***proficient*** range in the following sub-indicators:

- The institution properly administered TB medications for 21 of 23 applicable sampled patients (MIT 9.001, 91.3%). 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 all 23 sampled patients (MIT 9.002, 100%).
- The institution demonstrated proficiency in screening patients for TB for all 25 sampled patients (MIT 9.003, 100%).
- The institution demonstrated proficiency in offering influenza vaccinations during the most recently completed influenza season for all 25 sampled patients (MIT 9.004, 100%).
- The institution demonstrated proficiency in offering colorectal cancer screening to 24 of 25 patients (MIT 9.005, 96.0%). For one patient, 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 colonoscopy procedure completed according to the specialist recommendation.

- The institution offered immunizations to chronic care patients for all 10 applicable sampled patients (MIT 9.008, 100%).

Analysis of Performance Across Inspection Cycles

Figure 8. Preventative Services, Compliance Scores Across Cycles



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

In Cycle 8, VSP 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 97.9 percent in Cycle 8. This score follows ***inadequate*** performance results of 73.0 percent in Cycle 6 and 72.8 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

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	21	2	0	91.3%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent 90-day period they were on the medication? (9.002)	23	0	0	100%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	24	1	0	96.0%
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)	10	0	15	100%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **97.9%**

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

Compliance Recommendations

The OIG offers no compliance recommendations for this indicator.

Nursing Performance

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (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

VSP generally provided acceptable nursing care overall. The nurses performed well in case management, the transfer-in process, medication management, and specialty services. We also found nurses performed satisfactorily with opportunities for improvement in the following areas: outpatient, wound care, transfers-out, hospital returns, and specialized medical housing. However, we found VSP nurses needed improvement in assessments and interventions in emergency services. Considering all factors, the OIG rated this indicator ***adequate.***

Case Review Results

Table 20. Case Review Nursing Performance Results

Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
165	60	17

* We reviewed 165 nursing encounters in 38 cases. Of the nursing encounters we reviewed, 66 were in the outpatient setting,

† Deficiencies occurred in cases 1–3, 5–8, 16, 17, 19, 20, 24, 26–30, 32, 34, 36, 38–40, and 42–45.

‡ Significant deficiencies occurred in cases 1, 2, 5, 7, 8, 16, 19, 32, 39, 40, and 44.

Table 21. Case Review Outpatient Nursing Performance Results

Outpatient Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
66	27	8

* Nursing outpatient nursing encounters occurred in cases 1, 2, 6–8, 15–20, and 29–43. In the total number of nursing outpatient events, 43 were sick call events. Sick call events occurred in cases 1, 2, 6–8, 16, 17, 19, and 29–43.

† Outpatient nursing deficiencies occurred in cases 1, 6–8, 16, 19, 20, 29, 30, 32, 34, 36, 38–40, 42, and 43.

‡ Significant deficiencies occurred in cases 1, 8, 16, 19, 32, 39, and 40.

Performed well

OIG clinicians found VSP nurses performed well in the following:

- Case Management[58]

  We did not identify any deficiencies in case management; however, we only reviewed one case that contained case management events under our current methodology.

[58] We reviewed case management events in case 6.

- Transfers In[59]

  OIG clinicians found nurses screened patients appropriately and requested provider appointments within the required time frame. Please refer to the **Transfers** indicator for further details.

- Medication Management

  OIG clinicians found VSP nurses often administered medications properly and as prescribed. Please refer to the **Medication Management** indicator for further details.

- Specialty Services

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

Performed Satisfactorily, with Opportunities for Improvement

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

- Outpatient Nursing Assessment, Interventions, and Documentation

  The nurses triaged sick calls timely, generally performed good assessments, and intervened appropriately. OIG clinicians found a pattern of incomplete assessments, and nurses did not always co-consult with the provider when required. The following are examples:

  - In case 32, the nurse triaged a sick call request which stated, "I am dying and staff refuse to give me medical treatment." The nurse did not assess the patient on the same date the nurse triaged the sick call to ensure nothing urgent or emergent needed to be addressed. Two days later, the RN assessed the patient with a sick call complaint of bilateral ankle pain. The RN documented the patient had intermittent severe ankle discomfort and limited range of motion to bilateral ankles due to a strain, and the patient reported taking Tylenol. The nurse ordered a provider follow-up in 14 days. However, the nurse did not assess for any recent injuries, extremity strength, tone and sensation, the onset of symptoms, or the patient's gait; inquire on the dosage and frequency of Tylenol taken; or consult with the provider for a plan of care. The nurse also did not educate the patient. During the case review inspection, the institution agreed with the deficiency.

[59] A transfer-in nursing performance deficiency occurred in case 24. No significant deficiencies occurred.

- In case 39, the sick call RN assessed the diabetic patient for complaints of open wounds and bed sores for the past year. The patient's vital signs were stable. The nurse documented two wound sites on the patient's hips, one on the right and one on the left, both of which had "flaking, scar, weeping intermittent bleeding caused by flaking scabs." The nurse contacted the provider; however, the nurse did not do the following: inquire regarding previous treatment to bed sores or wounds and the last time the patient reported these wounds to medical; inquire on nutritional intake and any mobility issues; complete a thorough wound assessment to include the wound measurements, depth of the wound, and description of the surrounding tissue; document whether the wound was cleansed or dressed; document education provided to the patient; or initiate an RN follow-up order to reevaluate the wounds. During the case review inspection, the institution agreed with the deficiency.

- In case 40, the sick call nurse assessed the diabetic patient for complaints of right foot fungus, second toe from the left turning purple and nail coming off. The nurse documented the toenails were growing upwards and getting caught on the socks and initiated a provider follow-up in two weeks. However, the nurse did not complete any of the following: assess the right toe skin color, integrity, or intactness; assess right foot pedal pulse and mobility of right foot and toes; document the appearance of the toenails; complete vital signs; educate the patient; or consult with the provider for a plan of care to treat the toenail fungus and toenail abnormality for the diabetic patient. During the case review inspection, the institution agreed with the deficiency.

- Wound Care[60]

  Our clinicians reviewed six cases involving wound care and found nurses performed satisfactorily. We identified a pattern of incomplete wound assessments. The following is an example:

  - In case 19, on January 13, 2026, the RN assessed the patient for a one-day follow-up post-emergency department evaluation for incision and drainage (I&D) to the right collarbone area.[61] The patient was currently taking dual antibiotic therapy, clindamycin and doxycycline. The RN noted the patient had an incision with no active bleeding or discharge, and the nurse covered the incision with a dry dressing. The RN did not complete any of the following: perform wound care measurements to the right collarbone wound; perform vital signs; inquire on pain level; review medication compliance; educate the patient on signs and symptoms of infection, hygiene care, or when to return to

[60] We reviewed cases 8, 16, 19, 30, 39, and 45 for wound care. Deficiencies occurred in cases 19, 30, and 39. Significant deficiencies occurred in cases 19 and 39.

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

medical; or co-consult with a provider to determine whether wound care orders were required for a recent I&D to the right collarbone.

- Transfer-Out

  OIG clinicians found nurses screened patients appropriately and ensured all patients had their medical equipment. However, on a few occasions, we found nurses did not ensure the patient had their rescue or transfer medications. We also found nurses occasionally did not document all transfer information. Please refer to the **Transfers** indicator for further details.

- Hospital Returns

  OIG clinicians found nurses always assessed patients upon their return from community hospitals and emergency rooms; however, nurses intermittently did not perform complete assessments. Please refer to the **Transfers** indicator for further details.

- Specialized Medical Housing

  OIG clinicians found nurses completed timely admission assessments and initiated patient care plans. The nurses conducted daily rounds and generally performed appropriate assessments, interventions, and documentation. Please refer to the **Specialized Medical Housing** indicator for further details.

Performed Poorly, Improvement Needed

OIG clinicians found VSP nurses performed poorly in the following:

- Emergency Services

  Nurses needed improvement in assessments, interventions, and documentation. Please refer to the **Emergency Services** indicator for further details.

Clinician On-Site Inspection

Photo 21. B Facility RN Clinic Exam Room. Photographed on 6/16/26.

The OIG clinicians interviewed nursing staff and visited clinics B and C, medication rooms, the triage and treatment area (TTA), the receiving and release (R&R) area, and the outpatient housing unit (OHU). We attended huddles which were well organized, well attended, and had good staff participation. The nurses were familiar with their patient population and were knowledgeable about processes in their areas. Clinics B, C, and D had one clinic RN assigned, two providers, three to four medication LVNs, two medical assistants, and one care coordinator LVN. Office technicians collected the sick call slips during business hours. The A yard will be increasing their enhanced outpatient program (EOP) population and will be staffed with one RN and one psychiatric technician per building. The RN staff was currently in training. The nursing staff generally reported morale was good and described having a good rapport with nursing leadership and custody staff.

The chief nurse executive (CNE) was currently in an acting position at VSP and informed us she had worked at VSP for many years in various nursing positions. In addition to the A yard expansion, the CNE reported several new projects at VSP were underway to improve health care. First, one project underway was the new medication administration process in yards B, C, and D, where patients can obtain their medications at any window rather than going to an assigned window. The goal of this project is to decrease patient wait times to less than 30 minutes. The CNE reported it was working well. A second project underway was to improve colon cancer screenings which involved VSP patients participating in an educational commercial, which will be accessible to patients at other institutions to view on their tablets. A third project underway was the recent move of the supply warehouse to the outside perimeter of the institution, where ordering supplies is working well. A fourth project underway includes continuous cross training for the SRN staff. We were also informed the nursing instructors recently received a training and classroom space in the gym. The specialty nursing staff and the custody transportation team work well together. They

Photo 22. B Facility Clinic Hallway. Photographed on 6/16/26.

have daily calls with the warden, and VSP reported it has less than 50 percent back log for specialty appointments.

Case Review Recommendations

- Nursing leadership should determine the root cause(s) of challenges preventing nurses from completing thorough face-to-face assessments and co-consulting with providers when needed. 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 VSP providers generally delivered good care for their patients, which improved significantly compared with Cycle 7. We identified fewer deficiencies over a larger number of encounters. In addition, we found 27 of the 62 deficiencies (44 percent) concentrated in the three cases we rated ***inadequate***. Generally, providers performed well with documentation, continuity, review of records, and care for specialized medical housing patients. They also usually evaluated patients appropriately, referred them to specialists as clinically indicated, and followed through on specialists' recommendations. However, the providers required improvement in thorough evaluation of patients with diagnostic studies and addressing abnormal study results. Furthermore, providers often did not send or sent incomplete patient test result notification letters. After careful consideration of all provider performance factors, the OIG rated this indicator ***adequate***.

Case Review Results

Table 22. Case Review Provider Performance Results

Provider Encounters*	Deficiencies†	Significant Deficiencies‡
133	62	21

* The OIG reviewed 133 provider encounters. This is only the number of events where providers directly interacted with the patient. This does not include co-consults in the outpatient, provider-on-call, and urgent events.

† Deficiencies occurred in cases 2, 7–11, 13, 16–22, and 44.

‡ Significant deficiencies occurred in cases 7, 8, 16, 19, 21, and 22.

Table 23. Provider Performance Detailed Cases Results

Total Detailed Cases Reviewed	*Proficient*	*Adequate*	*Inadequate*
20	0	17	3

Performed Well

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

- Outpatient Documentation Quality[62]
- Provider Continuity[63]
- Outpatient Review of Records[64]
- Specialized Medical Housing[65]

Performed Satisfactorily with opportunities for improvement

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

- Chronic Care

  Providers usually managed their patients' chronic health conditions well, such as asthma, diabetes, hypertension, and hepatitis C. OIG clinicians identified five deficiencies, none of which was significant.[66] The following are examples:

  - In case 10, the provider evaluated the patient who had a fungal infection and elevated blood glucose level, which is often found in patients with diabetes. However, the provider did not order a hemoglobin A1c test to determine whether the patient had underlying diabetes.[67] The patient's risk factors for diabetes included hyperlipidemia, hypertension, and obesity.

[62] OIG clinicians did not identify any deficiencies in this sub-indicator.

[63] OIG clinicians identified one minor deficiency in this sub-indicator. In case 22, seven different providers participated in the patient's care through the review period.

[64] OIG clinicians did not identify any deficiencies in this sub-indicator.

[65] OIG clinicians identified one minor deficiency in case 44.

[66] Minor deficiencies occurred in cases 10, 13, 20, and 22.

[67] Hemoglobin A1c (HbA1c) is a blood test that measures the average plasma glucose over the previous 12 weeks and is used to diagnose diabetes. See https://www.cdc.gov/diabetes/diabetes-testing/prediabetes-a1c-test.html

- In case 13, the provider evaluated the patient with uncontrolled diabetes. The provider did not adjust the patient's diabetic regimen and ordered a follow-up to occur in three months when this should have occurred sooner.

- Emergency Care

  Providers appropriately managed patients in the TTA with emergent symptoms and were generally available to consult with the nurses. We identified six deficiencies related to emergency care.[68] OIG clinicians identified a pattern of providers not documenting progress notes for emergent events with four deficiencies. The following is an example:

  - In case 20, the patient presented to the TTA with severe abdominal pain. The provider ordered an EKG and administration of a GI cocktail. However, the provider did not document a progress note for this event.

  We discuss provider performance in emergency events further in the **Emergency Care** indicator.

- Outpatient Assessment and Decision-Making

  Providers usually performed appropriate assessments and made sound medical decisions. Providers generally diagnosed medical conditions correctly and referred their patients to specialists as medically indicated.[69] However, OIG clinicians identified a pattern in which providers did not always order appropriate testing or address abnormal diagnostic results. The following are examples:

  - In case 8, the provider evaluated the patient after the patient returned from a hospitalization but did not address the abnormal diagnostic test result that revealed the presence of bacteria in the blood. This increased the risk for a worsening and uncontrolled infection.

  - In case 16, the provider endorsed a urine test showing packed white blood cells together with many bacteria, suggestive of a urinary tract infection; however, the provider misinterpreted the test result and sent a patient letter stating the laboratory test was within normal limits.

- Specialty Services

  Overall, providers performed sufficiently in specialty services.[70] Providers generally ordered appropriate referrals for their patients and followed up on specialists' recommendations. However, OIG clinicians identified a pattern in which providers did

[68] Minor deficiencies occurred in cases 2, 8, 18, and 20.

[69] Deficiencies occurred in cases 7–11, 13, 16, 17, and 19–22. Significant deficiencies occurred in cases 7, 16, 19, 21, and 22.

[70] OIG clinicians identified deficiencies in cases 16, 20, and 22, one of which was significant.

not order appropriate referral priorities or follow-up with the specialists. The following is an example:

- In case 22, the provider ordered a prostate biopsy to be completed as routine priority (within 90 days), which increased the patient's risk for a delayed diagnosis of prostate cancer.

We also discuss provider performance in the **Specialty Services** indicator.

Performed Poorly, Improvement Needed

OIG clinicians found VSP performed poorly with improvement necessary in the following area:

- Patient Notification Letters

  Providers needed improvement in generating complete patient result notification letters. Test result notification is an important aspect of the patient's care and allows them to more fully understand their medical conditions. Providers often sent incomplete patient test result notification letters or did not send them at all.[71] The following are examples:

  - In case 5, the patient had a chest x-ray. However, the provider did not send the patient a test result notification letter.
  - In case 20, the provider endorsed an ultrasound study and generated a patient letter. However, the letter did not include whether the results were unchanged, or within normal limits, or as expected, or whether additional testing was needed.

  We also discuss further in the **Diagnostic Services** and **Health Information Management** indicators.

[71] Deficiencies occurred in cases 1, 2, 5, 7–10, 20–22, and 44, none of which were significant.

Clinician On-Site Inspection

We spoke with medical leadership and providers about VSP's medical care delivery. Medical leadership reported eight on-site providers, two telemedicine providers, 1.5 registry physicians, and three vacancies at the time of our on-site inspection. Medical leadership mentioned difficulties with hiring but not retaining providers. They commented many providers stayed for long periods of time, which ensured good patient continuity and no significant backlogs of provider appointments.

Photo 23. Provider clinic examination room. Photographed on 6-16-26.

The providers stated some recent increases in their workload related to administrative tasks based on CCHCS headquarters directives. All the providers expressed they experienced "good" or "excellent" morale both currently and during the period of review. Overall, they reported a collegial relationship with custody and nursing staff. The providers were unanimously enthusiastic about their interactions with medical leadership and stated leadership supported them. They felt comfortable bringing up difficult patient cases or situations to their colleagues during provider meetings or through discussions with the chief medical executive (CME) and chief physician and surgeon (CP&S). Altogether, they reported these positive interactions and the overall collaborative environment led to improved patient outcomes and close coordination of care across the various departments at VSP.

Medical leadership reported overall good provider morale and low staff turnover. They also reported an improvement in on-call volume through use of a nocturnist physician who covered on-call shifts from Monday to Thursday. Medical leadership expected providers to document physical examinations and co-consultations with the nurses. Additionally, the CP&S reviewed all on-call notes to ensure appropriate documentation. Medical leadership reviewed provider performance regularly through formal performance evaluations and through random chart audits.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

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, VSP's specialized medical housing consisted of an outpatient housing unit (OHU).

Specialized Medical Housing: Case Review Ratings and Results Summary

Case review found VSP provided sufficient care in the OHU. We found the institution performed well in provider performance and medication management. We found nurses generally performed appropriate assessments, interventions, and documentation with some opportunities for improvement. Considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Case Review Results

Table 24. Case Review Specialized Medical Housing Results

CTC Events*	Deficiencies†	Significant Deficiencies‡
62	8	3

* We reviewed three OHU cases that included 24 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 5, 44, and 45.

‡ Significant deficiencies occurred in cases 5 and 44.

Performed Well

OIG clinicians found VSP performed well in the following:

- Medication Management[72]
- Provider Performance[73]

Performed Satisfactorily with Opportunities for Improvement

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

- Nursing Performance[74]

  OIG clinicians found OHU nurses completed timely admission assessments and initiated patient care plans. The nurses conducted daily rounds, and generally performed appropriate assessments, interventions, and documentation. However, the following significant deficiencies show opportunities for improvement:

  - In case 5, the patient complained of severe radiating arm pain. The OHU LVN administered medication to the patient and documented that a report was provided to the treatment triage area (TTA) RN. However, the nurse did not document the name of the TTA RN the report was provided to. Additionally, the TTA RN did not immediately assess the patient for the urgent medical complaint. Instead, the TTA RN advised the OHU LVN to continue to monitor the patient. During the case review inspection, the institution agreed to the deficiency.

  - In case 44, the OHU RN changed the patient's indwelling foley catheter.[75] The patient refused to allow the nurse to fully insert the foley catheter per appropriate procedures. The nurse proceeded to comply with the patients request and inflated the catheter balloon without advancing the catheter and waiting for urine return which can cause injury. During the case review inspection, the institution agreed to the deficiency.

Performed Poorly, Improvement Needed

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

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[72] OIG clinicians did not identify any deficiencies in medication management.

[73] OIG clinicians identified one minor deficiency in case 44.

[74] Nursing performance deficiencies occurred in cases 5, 44, and 45. Significant deficiencies occurred in cases 5 and 44.

[75] An indwelling catheter is a soft plastic tube placed in the bladder to continuously drain urine into an external bag.

Clinician On-Site Inspection

While on site, we visited the OHU and observed the huddle. The huddle was organized, and the staff was familiar with their patients. The OHU had a designated provider who also covers the TTA. The OHU nursing staff consisted of an RN on the morning shift. The evening and the night shifts had an LVN assigned. Each shift also had a certified nursing assistant (CNA). Some of the duties of the RN on day shift included medication administration, patient assessments, and daily rounds with the provider. The OHU had 20 beds and during our on-site inspection, all 20 beds were occupied. The nursing staff reported they had a new process for ordering supplies, as the supplies were moved to a warehouse outside the prison. They informed us they had a new supervising registered nurse (SRN), they work well with custody staff, and their new administration was supportive.

Photo 24. OHU Patient Room.
Photographed on 6/17/2026.

Photo 25. OHU Hallway.
Photographed on 6/17/2026.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

Specialized Medical Housing: Compliance Ratings and Results Summary

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

Compliance Testing Results

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

- Providers performed excellently in completing written history and physical examinations within the required time frames for all five sampled patients (MIT 13.002, 100%).
- Providers exhibited proficiency in ordering medications within the required time frames upon the patient's admission for all four applicable sampled patients (MIT 13.003.1, 100%).
- Health care staff ensured all ordered medications were administered to the patient for all four sampled patients within the required time frames (MIT 13.003.3, 100%).
- The institution maintained an operational call light system during the on-site inspection (MIT 13.101, 100%).

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

- RNs demonstrated good performance in completing an initial assessment of the patient at the time of admission for four of five sampled patients (MIT 13.001, 80.0%). For one patient, the RN did not complete the initial assessment within the required time frame.

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

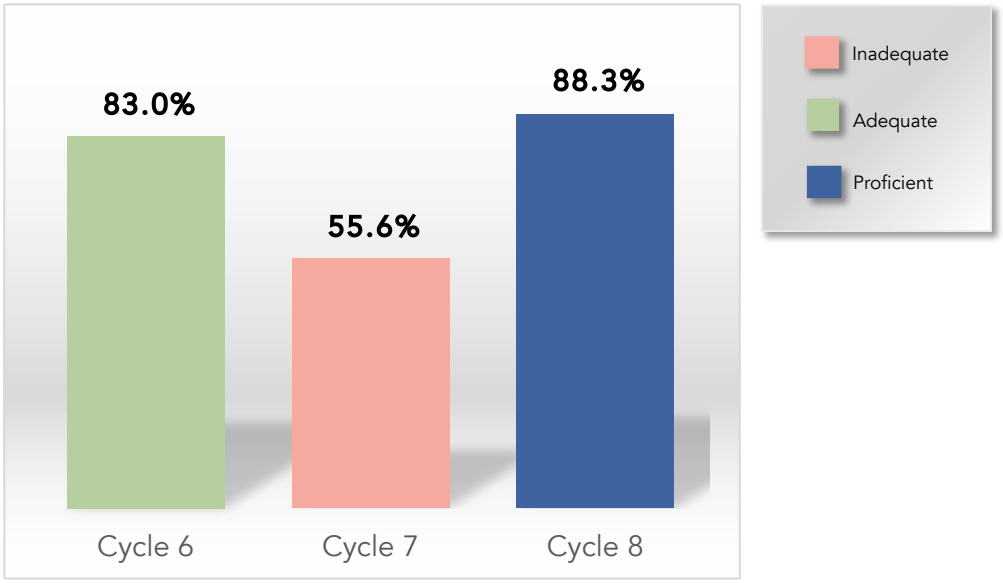
- Health care staff ensured all ordered medications were made available for only two of four applicable sampled patients within the required time frames (MIT 13.003.2, 50.0%). For two patients, the pharmacy was not timely in filling and dispensing medications as ordered.

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

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

Analysis of Performance Across Inspection Cycles

Figure 9. Specialized Medical Housing, Compliance Scores Across Cycles



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

In Cycle 8, VSP performed well above established standards. The institution successfully exceeded the 75.0 percent passing compliance threshold for this indicator, reaching a ***proficient*** score of 88.3 percent in Cycle 8. This score follows a previous ***adequate*** performance of 83.0 percent in Cycle 6 and a significantly regressed ***inadequate*** score of 55.6 percent in Cycle 7. The ***proficient*** performance this cycle demonstrates a successful recovery and significant positive growth in this indicator after a previous decline.

Table 25. Specialized Medical Housing Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001)	4	1	0	80.0%
Was a written history and physical examination completed within the required time frame? (13.002)	5	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)	4	0	1	100%
Upon the patient's admission to specialized medical housing: Were all ordered medications made available within required time frames? (13.003.2)	2	2	1	50.0%
Upon the patient's admission to specialized medical housing: Were all ordered medications administer or issued to the patient within required time frames? (13.003.3)	4	0	1	100%
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): **88.3%**				

Source: OIG VSP 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 VSP performed excellently in delivering specialty services for its patients. Improving from Cycle 7, VSP offered outstanding specialty services access. Providers and nurses also almost always assessed patients appropriately after specialty service appointments, and providers generally referred the patients to specialty services appropriately. Additionally, VSP staff managed health information well with retrieving, scanning, and endorsing specialty reports timely. After considering all factors, the OIG rated the case review component of this indicator ***proficient***.

Case Review Results

Table 26. Case Review Specialty Services Results

Specialty Services Related Events*	Deficiencies†	Significant Deficiencies‡
75	12	1

* These include 62 specialty consultations and procedures and 13 nursing encounters.

† Deficiencies occurred in cases 7, 16, 20, and 22.

‡ A significant deficiency occurred in case 22.

Performed Well

OIG clinicians found VSP performed well in the following areas:

- Access to Specialty Services[76]
- Health Information Management[77]
- Nursing Performance[78]

Performed Satisfactorily, with Opportunities for Improvement:

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

- Provider Performance[79]

  Providers performed sufficiently in ordering specialty service referrals and procedures timely with the appropriate time priority. Providers endorsed the specialty reports timely and usually followed through with specialists' recommendations. However, OIG clinicians identified four minor deficiencies and one significant deficiency. The following is an example of a minor deficiency:

  - In case 22, the provider evaluated the patient following a prostate biopsy performed by the specialist. However, the provider did not place an order to obtain the pathology results per CCHCS policy. VSP staff obtained the official biopsy results over four weeks later. This deficiency was partially mitigated because the urologist discussed the results with the patient two weeks after the provider appointment. During the case review inspection, VSP agreed with this deficiency.

  We also discuss further in the **Provider Performance** indicator.

Performed Poorly, Improvement Needed

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

[76] Two minor deficiencies occurred in cases 16 and 22.

[77] Four minor deficiencies occurred in cases 7 and 22.

[78] One minor deficiency occurred in case 7.

[79] Four minor deficiencies occurred in cases 16, 20, and 22. One significant deficiency occurred in case 22.

Clinician On-Site Inspection

The OIG clinicians met with the CSE, specialty SRN, and utilization management (UM) nurse to discuss the processes within specialty services. The CSE reported the nursing staff received specialty service reports and sent them to the HIM department for scanning into the EHRS. Additionally, HIM staff would sometimes receive reports directly from the hospital or specialists' offices. The CSE stated the specialty department coordinated with HIM to ensure timely receipt and scanning of specialty reports.

We discussed specialty service care with the SRN. The SRN reported an appointment backlog of 37 off-site and on-site specialty appointments but stated 32 had been scheduled. On-site specialty services included audiology, gastroenterology, ophthalmology, optometry, orthotics, and physical therapy. The UM nurse reported some difficulties in timely appointment access to off-site specialty services, such as neurology. Providers did not report any significant difficulties in obtaining specialist appointments timely and used eConsult if they required interim guidance for patient care.[80] The SRN reported close collaboration between custody and medical staff to ensure patients were transported to off-site specialist appointments without rescheduling due to staffing issues.

Patients returning from specialty service appointments usually brought back preliminary hand-written recommendations. VSP would later receive formal dictated specialty reports which HIM

Photo 26. Physical therapy room.
Photographed on 6-16-2026.

Photo 27. Physical therapy equipment.
Photographed on 6-16-2026.

staff would then scan into EHRS. HIM staff tracked the timely receipt of specialist reports using a detailed spreadsheet. They reported occasional difficulties in timely receiving specialty reports despite contacting the specialists' office staff. HIM staff scanned received reports into the EHRS within 24 to 48 hours of receipt from the hospital or specialist office. However, the delay in receiving the report resulted in the subsequent late scanning of some specialty reports into the

[80] An eConsult is an electronic specialty consulting service whereby providers can ask specialists medical questions and receive advice and recommendations for patient care.

EHRS. HIM staff stated they reported their concerns in obtaining reports timely from the specialists to VSP leadership.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

Specialty Services: Compliance Ratings and Results Summary

Compliance Rating

ADEQUATE

Compliance Score

(80.8%)

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

Compliance Testing Results

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

- The institution achieved proficiency in ensuring providers reviewed the high-priority specialty service consultant reports within the required time frames in all five applicable sampled patients (MIT 14.002.2, 100%).
- The institution provided subsequent follow-up appointments after a high-priority specialty service for all four applicable sampled patients (MIT 14.003, 100%).
- The institution achieved proficiency in ensuring patients received medium-priority specialty services within 15 to 45 calendar days for 13 of 15 sampled patients (MIT 14.004, 86.7%). For two patients, the services were provided one and 20 days late.
- The institution achieved proficient performance in ensuring providers reviewed the medium-priority specialty service consultant reports 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 two days late.
- The institution ensured patients timely received their routine-priority specialty services within 90 calendar days for 13 of 15 patients (MIT 14.007, 86.7%).
- The institution ensured providers reviewed the routine-priority specialty service consultant reports within the required time frames for all 13 applicable sampled patients (MIT 14.008.2, 100%).
- The institution demonstrated proficiency in timely denying the request for services (RFS) as required by CCHCS policy for 10 of 11 sampled patients (MIT 14.011, 90.9%). For one patient, the institution denied the RFS three days late.

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

- The institution provided timely subsequent follow-up appointments after a medium-priority specialty service for eight of 10 applicable sampled patients (MIT 14.006, 80.0%). For two patients, the services were provided 33 and 70 days late.

- The institution received routine-priority specialty service consultant reports within the required time frames for 10 of 12 applicable sampled patients (MIT 14.008.1, 83.3%). For two patients, the reports were received two and four days late.

- The institution performed satisfactorily in providing subsequent follow-up appointments after a routine-priority specialty service for nine of 11 applicable sampled patients (MIT 14.009, 81.8%). For two patients, the services were provided 10 and 62 days late.

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

- The institution ensured patients received high-priority specialty services within 14 calendar days for four of seven patients (MIT 14.001, 57.1%). For three patients, the service was provided between six and 108 days late. Specifically for two patients, the appointments were late due to institution custody transportation delays. One patient missed an appointment because of a transportation scheduling mix-up. The other patient faced consecutive delays and multiple rescheduled appointments stemming from an initial ambulance blockage in the sally port, which caused late arrival to the specialist's facility, a subsequent facility turn-away for another late arrival, and a facility turn-away due to a missing X-ray technician at the specialty facility.

- The institution received high-priority specialty service consultant reports within the required time frames for five of seven applicable sampled patients (MIT 14.002.1, 71.4%). For two patients, the record contained no evidence the institution received the specialist's report.

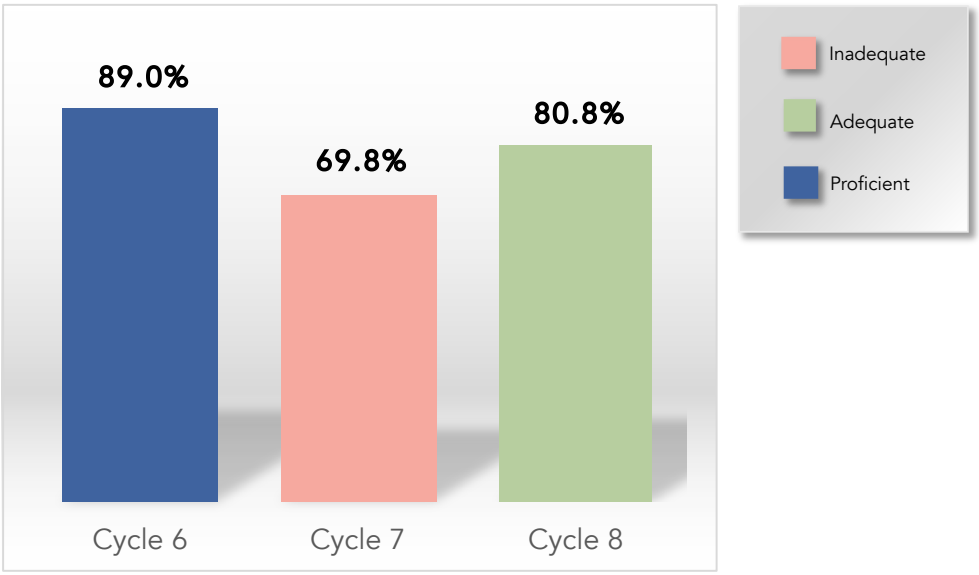
- The institution received medium-priority specialty service consultant reports within the required time frames for nine of 15 sampled patients (MIT 14.005.1, 60.0%). For six patients, the reports were received between one and 16 days late.

- The institution ensured patients timely received their pre-approved specialty service appointments for patients endorsed from another institution in 12 of 20 sampled patients (MIT 14.010, 60.0%). For six patients, the services were provided between 12 and 57 days late. For the remaining two patients, the record contained no evidence the specialty service appointment occurred during our review period.

- Providers informed six of 10 applicable sampled patients of the denied RFS within the required time frame (MIT 14.012, 60.0%). For four patients, the record contained no evidence the provider discussed the denied specialty service request with the patient.

Analysis of Performance Across Inspection Cycles

Figure 10. Specialty Services, Compliance Scores Across Cycles



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

In Cycle 8, VSP met established standards, maintaining an ***adequate*** rating. The institution met the 75.0 percent passing compliance threshold for this indicator, reaching a score of 80.8 percent in Cycle 8. This score follows a prior ***proficient*** score of 89.0 percent in Cycle 6 and a subsequent regression to an ***inadequate*** score of 69.8 percent in Cycle 7. The improvement to a high ***adequate*** score indicates the institution rebounded from its previous drop below the compliance threshold; however, the current performance still represents a minor decline from its ***proficient*** performance in Cycle 6.

Compliance Score Results

Table 27. 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)	4	3	0	57.1%
Did the institution receive the high-priority specialty service consultant report within the required time frame? (14.002.1)	5	2	0	71.4%
Did the institution review the high-priority specialty service consultant report within the required time frame? (14.002.2)	5	0	2	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)	4	0	3	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)	13	2	0	86.7%
Did the institution receive the medium-priority specialty service consultant report within the required time frame? (14.005.1)	9	6	0	60.0%
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)	8	2	5	80.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	13	2	0	86.7%
Did the institution receive the routine-priority specialty service consultant report within the required time frame? (14.008.1)	10	2	3	83.3%
Did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008.2)	13	0	2	100%
Did the patient receive the subsequent follow-up to the routine- priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.009)	9	2	4	81.8%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	12	8	0	60.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	10	1	0	90.9%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	6	4	1	60.0%
			Overall percentage (MIT 14):	**80.8%**

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 or approved follow-up specialty appointments. Leadership should implement and monitor remedial measures as appropriate.
- The department should develop measures to ensure institutions timely receive specialty reports. 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

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

Compliance Testing Results

VSP 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 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 reviewed and completed the initial patient death reports timely for all 11 sampled patients (MIT 15.102, 100%).

- The medical leadership completed clinician performance appraisals timely for eight of nine sampled clinicians (MIT 15.104, 88.9%). For one appraisal, the medical leadership failed to provide a complete ongoing professional practice evaluation (OPPE) timely.

- All 13 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 its designee(s) completed the multidisciplinary review of the significant events leading to all 10 patient deaths during our review period (MIT 15.998 [scored component], 100%).

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

- Supervising registered nurses ensured the clinical competency of seven of 10 nurses administering medications were timely completed during our review period (MIT 15.103, 70.0%). For three nurses, the institution failed to provide the competency testing within the required time frames.

- The institution ensured six of 10 newly hired nurses completed the required onboarding and clinical competency processes (MIT 15.108, 60.0%). For four nurses, the nursing instructor failed to complete the onboarding checklist. Specifically, the checklist did not include the nursing instructor's initials.

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

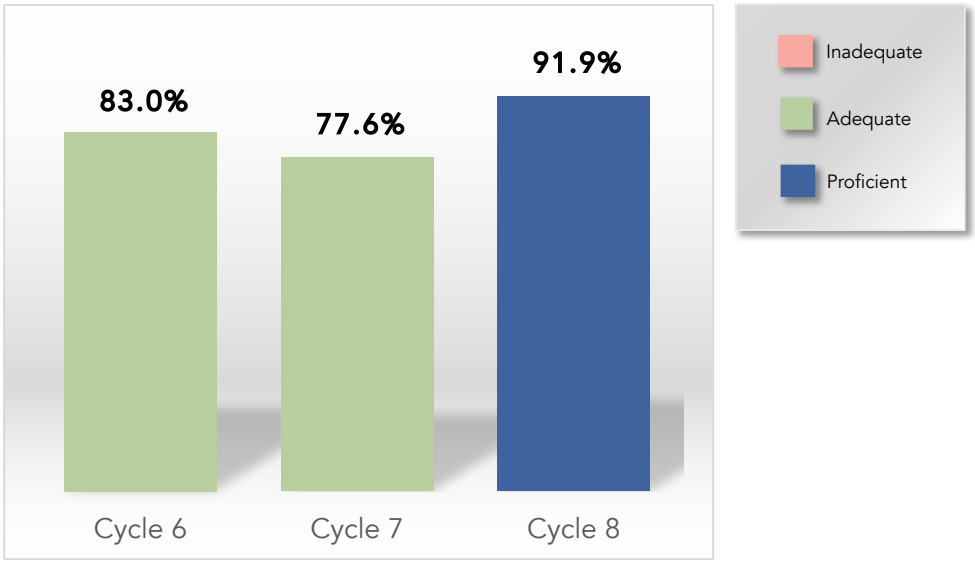
- We reviewed one sentinel event reported during our inspection period. The institution did not meet the root cause analysis (RCA) reporting requirements. Specifically, they reported the sentinel event to the Health Care Incident Review Committee (HCIRC) 52 days late (MIT 15.001, N/A).

- We determined the test for MIT 15.003 is not applicable because VSP does not have a Correctional Treatment Center (CTC) or Skilled Nursing Facility (SNF) (MIT 15.003, 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 10 patient death reports (MIT 15.998 [non-scored component], N/A).

Analysis of Performance Across Inspection Cycles

Figure 11. Administrative Operations, Compliance Scores Across Cycles



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

In Cycle 8, VSP performed above established standards, reaching a ***proficient*** score in Cycle 8. The institution surpassed the 75.0 percent passing compliance threshold for this indicator, reaching 91.9 percent in Cycle 8. This score follows a previous ***adequate*** score of 83.0 percent in Cycle 6 and a subsequently regressed ***adequate*** score of 77.6 percent in Cycle 7. The institution's significant score increase in this cycle demonstrates that VSP has successfully implemented significant improvements and is now performing well above established benchmarks in this indicator.

Compliance Score Results

Table 28. Administrative Operations Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For informational purposes only: For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This test is not scored. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.003)	N/A	N/A	N/A	N/A
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)	11	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.103)	7	3	0	70.0%
Did physician managers complete provider clinical performance appraisals timely? (15.104)	8	1	0	88.9%
Did the providers maintain valid state medical licenses? (15.105)	13	0	0	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.106)	5	0	2	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.107)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.108)	6	4	0	60.0%
Did the institution's CEO or designee(s) complete a multidisciplinary review of the significant events leading to the patient's death timely? For informational purposes only: Did the Headquarters Mortality Case Review process mortality review reports timely (15.998)?	10	0	0	100%
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This test is not scored. Please refer to Table 3 for CCHCS- provided staffing information.			
	Overall percentage (MIT 15): **91.9%**			

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

Compliance Recommendations

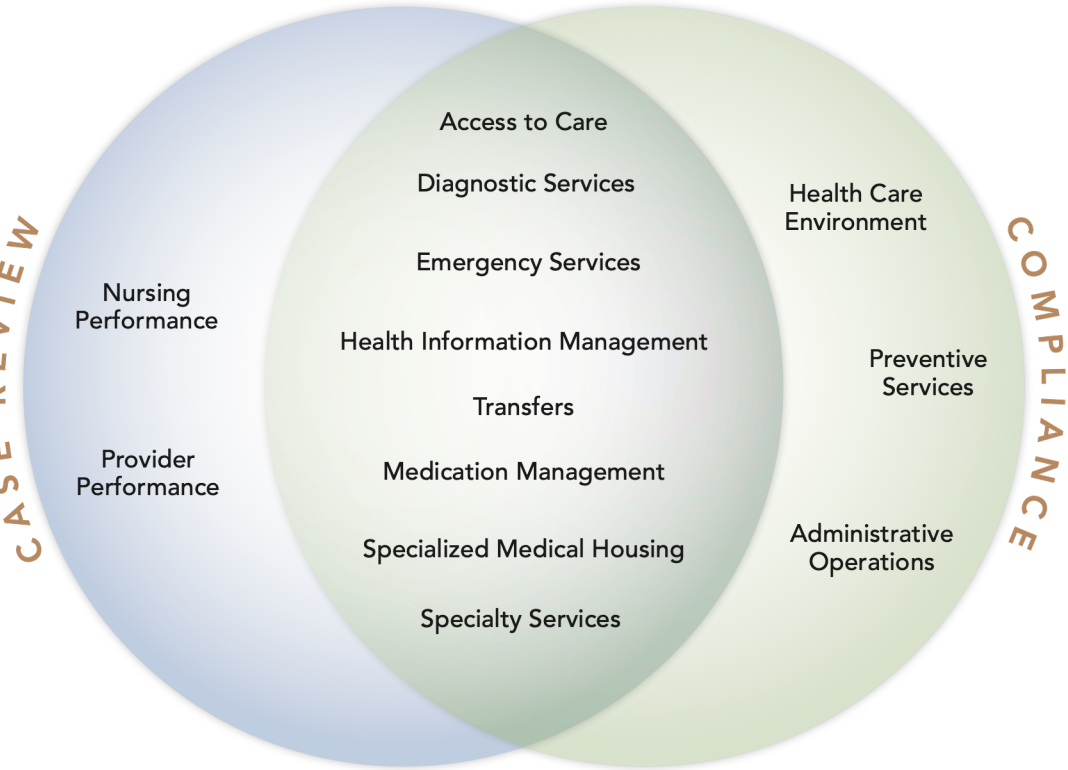
The OIG offers no compliance recommendations for this indicator.

Appendix A: Methodology[81]

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

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

Figure 12. Inspection Indicator Review Distribution for VSP



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 8 medical inspections. Below, Table 29 provides important definitions that describe this process.

Table 29. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

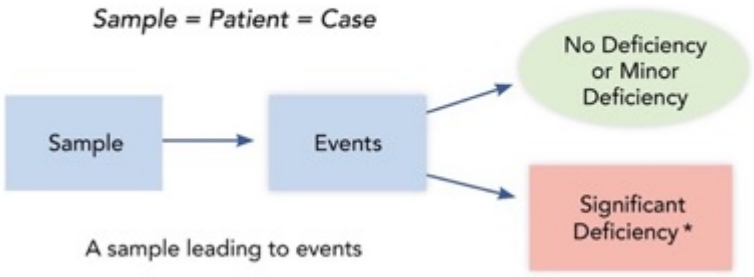
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

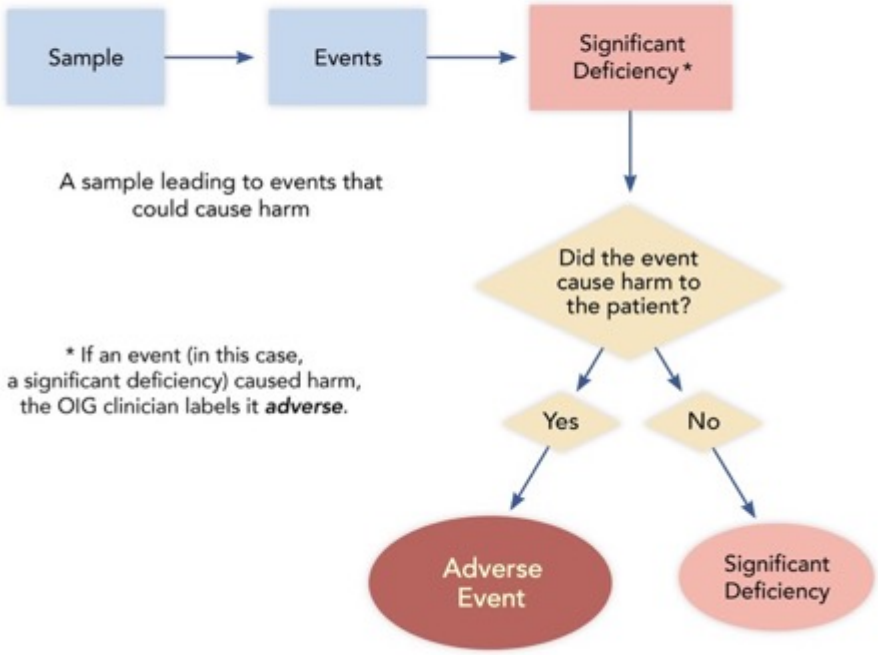
Figure 13. Case Review Testing

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



Deficiencies

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



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

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B: Case Review Data

Table 30. VSP Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	2
Death Review/Sentinel Events	4
Diabetes	3
Emergency Services – CPR	2
Emergency Services – Non-CPR	2
High Risk	3
Hospitalization	3
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	15
Specialty Services	2
	45

Table 31. VSP Case Review Chronic Care Diagnoses

Anemia	5
Anticoagulation	5
Arthritis/Degenerative Joint Disease	9
Asthma	6
COPD	5
COVID-19	2
Cancer	2
Cardiovascular Disease	8
Chronic Kidney Disease	8
Chronic Pain	11
Cirrhosis/End Stage Liver Disease	4
Coccidioidomycosis	1
Diabetes	16
Gastroesophageal Reflux Disease	12
Hepatitis C	14
Hyperlipidemia	30
Hypertension	23
Mental Health	24
Migraine Headaches	1
Seizure Disorder	5
Sleep Apnea	5
Substance Abuse	13
Thyroid Disease	4
	213

Table 32. VSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	139
Emergency Care	61
Hospitalization	29
Intrasystem Transfers In	9
Intrasystem Transfers Out	7
Outpatient Care	359
Specialized Medical Housing	62
Specialty Services	83
	749

Table 33. VSP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	2
RN Reviews Detailed	10
RN Reviews Focused	27
Total Reviews	59
Total Unique Cases	45
Overlapping Reviews (MD & RN)	14

Appendix C: Compliance Sampling Methodology

Valley State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (1–7 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	37	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (30 days–7 months) • Randomize
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (30 days–7 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (30 days–7 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal

MITs 2.010–012	Pathology	10	InterQual	• Appt. date (30 days–7 months) • Service (pathology-related) • Randomize
Emergency Services				
MIT 3.001	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MITs 3.101 - 103	Clinical Areas	9	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
MIT 3.104	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 3.105	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	37	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	25	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	25	Documents for any tested incarcerated person	• Arrival date (12 months) • Any misfiled or mislabeled document identified during OIG compliance review • Randomize
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site admissions	• Date (1–7 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Quality	**Sample Category**	**No. of**	**Data Source**	**Filters**

Indicator		Samples		
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	9	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	3	OIG inspector on-site review	• R&R IP transfers with medication
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals–Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intra-facility 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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 7.006	En Route	10	SOMS	• Date of transfer (1–7 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	5	Medication error reports	• All medication error reports • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	7	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	23	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month

				• Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (age 45 –75) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 40 –74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 21 – 65) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP — any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 bus days prior to inspection date) • All
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (1–7 months) • Arrived from (county jail, return from parole, etc.) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	5	CADDIS	• Admit date (1–7 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	7	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

Specialty Services (continued)				
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	11	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (12 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	LGB	N/A at this institution	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	11	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
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	9	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.105	Provider Licenses	13	Current provider listing (at start of inspection)	• Review all
MIT 15.106	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.107	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.108	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

California Correctional Health Care Services' Response

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September 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 Valley State Prison. Thank you for preparing the report.

If you have any questions or concerns, please contact me at (916) 691-1655.

Sincerely,

DocuSigned by:
Corina Vitale
7DFF41FD5D61455...

Corina Vitale
Supervisor I
Policy and Risk Management Services
California Correctional Health Care Services

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Sarah Hartmann, Chief Counsel, CCHCS Office of Legal Affairs
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Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Debra Amos-Terrell, 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 II, CCHCS
Chief Executive Officer, VSP
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

Valley State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
September 2026

OIG