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California State Prison,
Solano

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 people¹ in the California Department of Corrections and Rehabilitation (the department).²

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

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

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

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

¹ In this report, we use the terms *patient* and *patients* to refer to *incarcerated people*.

² The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

³ In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for comparison purposes.

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

As we did during Cycle 7, the OIG continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. Our statutory mandate provides no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. However, in accordance with the legislature’s interest in focusing on the undelegated institutions, the OIG scheduled our medical inspections of the three remaining undelegated institutions earlier in our Cycle 8 inspection calendar.⁶ At the time of the Cycle 8 inspection of California State Prison, Solano (SOL), the receiver had delegated SOL back to the department in 2024.

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

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

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

Summary: Ratings and Scores

We completed the Cycle 8 inspection of California State Prison, Solano (SOL) in July 2026.⁷ OIG inspectors monitored the institution's delivery of medical care that occurred during the specified review periods.



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



The OIG rated the compliance component of the overall health care quality at SOL as ***adequate (82.6%)***.

OIG case review clinicians—a team of Physicians & Surgeons (physicians) and Nursing Consultants, Program Review (NCPRs)—reviewed 69 cases, which contained 807 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 July 2026 to verify their initial findings. OIG clinicians evaluated the quality of care for a total of 87 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

⁷ Samples are obtained per case review methodology shared with stakeholders in prior cycles. The general inspection period includes samples from November 2025 to May 18, 2026, as well as on-site observations during May 2026 and July 2026; however, the OIG may review samples outside the general inspection period as dictated by our methodologies. The case reviews include emergency CPR reviews during August 2025, death reviews between August 2025 and February 2026, and correctional treatment center reviews between June 2025 and February 2026.

⁸ For our detailed and focused case reviews, our clinicians reviewed medical charts and events for 69 unique patients. Both physicians and NCPRs reviewed 18 of those cases, for a total of 87 detailed and focused case reviews.

concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.⁹

To evaluate the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies set forth in the department's Health Care Department Operations Manual (HCDOM)¹⁰ by applying a standardized set of test questions that measure specific elements of health care delivery as required under the HCDOM. Our compliance inspectors examined 401 patient records and 1,177 data points, and we used the data to assess 102 MIT questions. We also observed SOL's processes during an on-site inspection in June 2026.

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

Overall Medical Inspection Results

Case Review Results

OIG case reviewers assessed 10 of the 15 indicators applicable to SOL. OIG clinicians rated one of these indicators *proficient*, nine *adequate*, and none *inadequate*. In the 807 events reviewed, we identified 232 deficiencies, 61 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm. We solely tested **Nursing Performance** and **Provider Performance** in clinical case review as these indicators do not have a compliance component.

Adverse Events Identified During Case Review

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

Compliance Testing Results

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

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

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

¹¹ The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to SOL.

We list the individual indicators and ratings applicable for this institution in Table 1 below.

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

		Ratings		Scoring Ranges			
		Proficient	Adequate	Inadequate	100%–85.0%	84.9%–75.0%	74.9%–0
MIT Number	Health Care Indicators	Case Review		Compliance			
		Cycle 8	Change Since Cycle 7*	Cycle 8	Cycle 7	Change Since Cycle 7*	
1	Access to Care	Proficient	↑	79.9%	82.7%	=	
2	Diagnostic Services	Adequate	=	71.9%	59.8%	=	
3	Emergency Services	Adequate	=	59.7%	N/A	N/A	
4	Health Information Management	Adequate	=	87.3%	87.1%	=	
5	Health Care Environment	N/A	N/A	96.8%	54.3%	↑	
6	Transfers	Adequate	=	81.7%	86.0%	↑	
7	Medication Management	Adequate	=	82.2%	76.7%	=	
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A	
9	Preventive Services	N/A	N/A	93.7%	68.2%	↑↑	
10	Nursing Performance	Adequate	=	N/A	N/A	N/A	
11	Provider Performance	Adequate	=	N/A	N/A	N/A	
12	Reception Center	N/A	N/A	N/A	N/A	N/A	
13	Specialized Medical Housing	Adequate	=	75.0%	85.7%	↑	
14	Specialty Services	Adequate	↑	80.8%	52.7%	↑	
15	Administrative Operations	N/A	N/A	100%	74.4%	↑↑	

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

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

Institution-Specific Metrics

California State Prison, Solano (SOL), is located in the city of Vacaville and operates as a medium-security institution housing general population incarcerated people. SOL maintains medical clinics where medical staff address routine requests for medical services. SOL also conducts patient screenings in its receiving and release clinic (R&R), treats patients requiring urgent or emergent care in its triage and treatment area (TTA), and houses patients requiring inpatient health care services in its correctional treatment center (CTC). SOL has been designated as an *intermediate care prison*, providing outpatient health care services through its clinics, which handle nonurgent requests for medical services. Patients needing urgent or emergent care are treated in its triage and treatment area (TTA) and patients requiring inpatient health services are cared for in its correctional treatment center (CTC).

On April 20, 2026, the Health Care Services Master Registry showed SOL had a total population of 2,908. A breakdown of the medical risk level of the SOL population as determined by the department is set forth in Table 2 below.¹²

Table 2. SOL Master Registry Data as of April 2026

Medical Risk Level	Number of Patients	Percentage*
High 1	203	7.0%
High 2	304	10.5%
Medium	758	26.1%
Low	1,643	56.5%
Total	2,908	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 April 20, 2026.

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, SOL had no vacant executive leadership position, 2.0 primary care provider vacancies, 0.2 nursing supervisor vacancies, and 4.7 nursing staff vacancies.

Table 3. SOL Health Care Staffing Resources as of April 2026

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions‡	5.0	12.0	11.7	113	141.7
Filled by Civil Service	5.0	5.0	11.5	111.1	132.6
Vacant	0	2.0	0.2	4.7	6.9
Percentage Filled by Civil Service	100%	41.7%	98.3%	98.3%	93.6%
Filled by Telemedicine	0	4.0	0	0	4.0
Percentage Filled by Telemedicine	0	33.3%	0	0	2.8%
Filled by Registry	0	1.0	0	1.0	2.0
Percentage Filled by Registry	0	8.3%	0	0.9%	1.4%
Total Filled Positions	5.0	10.0	11.5	112.1	138.6
Total Percentage Filled	100%	83.3%	98.3%	99.2%	97.8%
Appointments in Last 12 Months	0	1.0	1.0	11.0	13.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	1.0	2.0	3.0
Adjusted Total: Filled Positions	5.0	10.0	10.5	110.1	135.6
Adjusted Total: Percentage Filled	100%	83.3%	89.7%	97.4%	95.7%

* 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 April 20, 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 SOL'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 the statewide Medi-Cal program—California Medi-Cal, and Kaiser Permanente, SOL'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. SOL had a 30 percent influenza immunization rate for adults 18 to 64 years old and a 62 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal immunization rate was 92 percent.

Cancer Screening

Statewide comparative data was available for colorectal cancer screening. When compared with the statewide Medi-Cal program-California Medi-Cal, and Kaiser Permanente, SOL had a 95 percent colorectal cancer screening rate, a rate higher and thus better than California Medi-Cal and Kaiser Permanente.

Table 4. SOL Results Compared to State HEDIS Scores

HEDIS Measure	SOL Cycle 8 Results*	California Medi-Cal†	Kaiser Permanente‡
Diabetic Population			
Poor HbA1c Control (>9.0%) †, §	5%	29%	20%
HbA1c Control (<8.0%) ‡	85%	–	–
Blood Pressure Control (<140/90) ‡	94%	–	–
HbA1c Screening	94%	–	–
Eye Exams	78%	–	–
Immunizations			
Influenza - Adults (18–64)	30%	–	–
Influenza - Adults (65+)	62%	–	–
Pneumococcal – Adults (65+)	92%	–	–
Cancer Screening			
Colorectal Cancer Screening	95%	40%	79%

* Unless otherwise stated, data were collected in May 2026 by reviewing medical records from a sample of SOL'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 SOL 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 referrals to 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 SOL performed well in delivering access to care for its patients. SOL offered excellent provider access to clinic and specialized medical housing patients. Additionally, staff timely completed appointments for follow-up after hospitalizations, transferring into the institution, urgent or emergent care, and specialty service. SOL also performed satisfactorily with access to clinic nurses and specialty service appointments. After considering all aspects, the OIG rated the case review component of this indicator *proficient*.



Case Review Results

Table 5. Access to Care Case Review Results

Total Cases Reviewed*	Deficiencies†	Significant Deficiencies‡
69	13	5

* The OIG reviewed 69 cases.
† Deficiencies occurred in cases 1, 9, 15, 18, 20, 22, 24, 31, 54, and 68.
‡ Significant deficiencies occurred in cases 15, 18, 20, 22, 24, and 68.

Performed Well

OIG clinicians found SOL performed well in the following areas:

- Access to Clinic Providers¹³
- Access to Specialized Medical Housing Providers¹⁴
- Follow-up After Hospitalizations¹⁵
- Follow-up After Transferring Into SOL¹⁶
- Follow-up After Urgent or Emergent Care¹⁷
- Follow-up After Specialty Services¹⁸

Performed Satisfactorily with Opportunities for Improvement

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

- Access to Clinic Nurses¹⁹

SOL performed satisfactorily in access to clinic nurses. However, OIG clinicians identified a minor pattern in which nurses did not timely evaluate patients with symptomatic sick call requests. The following are examples:

- In case 1, the patient submitted a sick call request for symptoms of numbness in his fingers and toes. Instead of assessing the patient within one business day, the nurse assessed the patient two days later.
- In case 54, the patient submitted a sick call request for symptoms of a splinter causing finger pain. However, the patient did not receive an appointment within one business day.

¹³ Minor deficiencies occurred in cases 9 and 24

¹⁴ A minor deficiency occurred in case 31.

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 Deficiencies occurred in cases 1, 15, 18, and 68. Significant deficiencies occurred in cases 15, 18, and 68.

- Access to Specialty Services²⁰

SOL performed acceptably in access to specialty appointments. However, OIG clinicians identified a minor pattern of patients not receiving timely specialist care. The following is an example:

- In case 15, the patient received an EGD procedure three days late.²¹

We also discuss Specialty Service access in the **Specialty Services** Indicator.

Performed Poorly, Improvement Needed

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

Clinician On-Site Inspection

OIG clinicians inspected the clinical care areas of the institution. SOL has a central health clinic (CHC), where all providers and nurses evaluate and treat patients in an outpatient setting. Patient care teams include providers, nurses, and medical staff. Eight patient care teams are assigned to specific patients based on the last two numbers of the patients' CDCR numbers. None of these care teams are assigned specific examination rooms. The care teams instead rotate to examination rooms based on where their patients are located on the yards. Of the 11 providers in the patient care teams, three are telemedicine physicians.

The OIG clinicians interviewed the outpatient scheduling supervisor (OSS) and medical staff to discuss SOL's clinics and appointment processes. The OSS stated the scheduling department had been short staffed since April 2026 and had filled only two of five vacant positions. The OSS reported a hiring freeze as one reason for the inability to fill the vacancies. When asked about any provider appointment backlogs, the OSS stated the backlog was minimal, not exceeding five appointments in the last month. Providers evaluated an average of eight patients per day. Provider appointment schedules contained closer to 10 patients if the provider had a backlog.

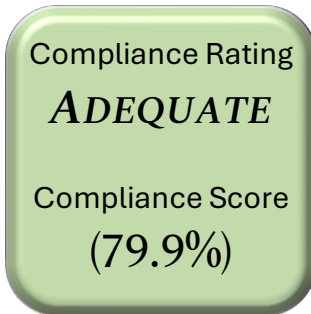
Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

²⁰ Deficiencies occurred in cases 15, 20, 22, and 24. Four significant deficiencies occurred in cases 20, 22, and 24.

²¹ An EGD is an esophagogastroduodenoscopy. In this procedure, the specialist uses a camera to examine the esophagus and the stomach.

Access to Care: Compliance Ratings and Results Summary



SOL performed satisfactorily in this indicator. Based on the overall compliance score result of 79.9 percent, the OIG rated the compliance component of this indicator *adequate*.

Compliance Testing Results

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

- Following the review of the patients' submitted health care service request forms (CDCR Forms 7362), registered nurses (RNs) completed face-to-face appointments for 36 of 40 sampled patients within one business day (MIT 1.004, 90.0%). For two patients, the appointments occurred three and four days late. For one patient, nursing staff did not document the visit using the required Subjective, Objective, Assessment, and Plan (SOAP) format. For the remaining patient, the record contained no evidence a refusal form was completed during our review period.
- In 17 applicable samples where an RN identified the need for a primary care referral, 15 were seen within the required time frames according to the priority level assigned to their appointment (MIT 1.005, 88.2%). For one patient, the record contained no evidence a refusal form was completed during our review period. For the remaining patient, the record contained no evidence the appointment occurred during our review period.
- The institution attained a perfect score in ensuring all follow-up provider sick call appointments occurred within the specific time frames ordered by the primary care provider (MIT 1.006, 100%).
- Providers completed post-discharge follow-up appointments for 15 of 17 sampled patients within the required time frames (MIT 1.007, 88.2%). For two patients, the record contained no evidence the patient completed a refusal form for a follow-up appointment after hospitalization during our review period.

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

- When new patients arrive at the institution, the patients must either receive an RN assessment or a provider evaluation, depending on their clinical risk level. Providers maintained their workflows and completed their comprehensive patient appointments for 19 of 24 applicable sampled patients referred for provider appointment (MIT 1.002,

79.2%). For three patients, the record contained no evidence the patient completed a refusal form during our review period. For two patients, the record contained no evidence the appointment occurred during our review period.

- Nursing staff performed satisfactorily in adhering to triage documentation standards. Staff met the full requirements for a completed review upon receipt of the CDCR Form 7362 for 33 of 40 sampled patients (MIT 1.003, 82.5%). For seven patients, nursing staff failed to accurately complete the CDCR Form 7362 with the required printed or stamped name and their signature.

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

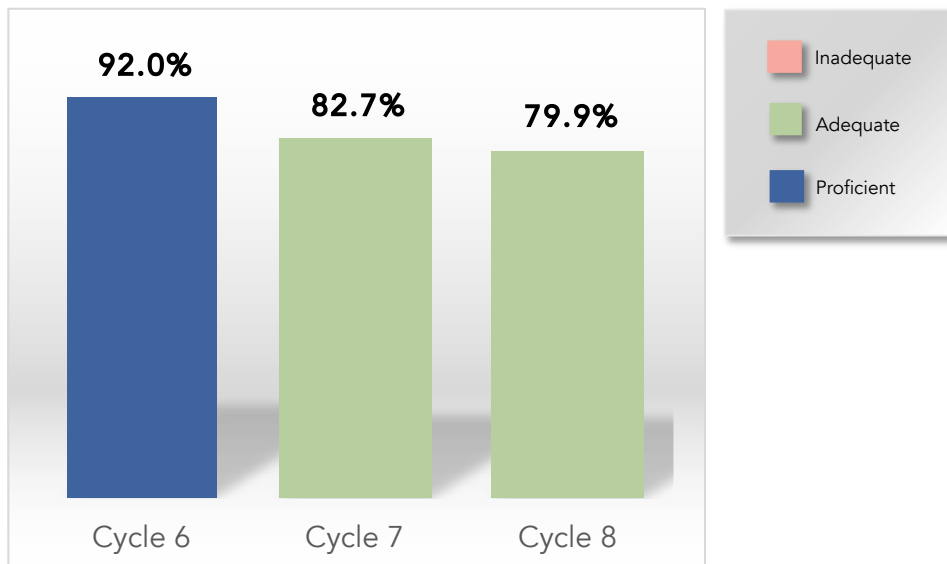
- The institution conducted the most recent chronic care appointments within the specified time frames for only 13 of 25 sampled patients (MIT 1.001, 52.0%). For five patients, the appointments occurred between two and 301 days late. For four patients, the record contained no evidence the patient completed a refusal form during our review period. For three patients, the record contained no evidence the appointment occurred during our review period.
- The institution struggled to comply with requirements when patients returned from specialty services. In only 18 of these 25 applicable sampled patients, the institution either met mandated timelines for provider follow-up appointments or, in cases involving medium- or routine-priority specialty services in which a patient did not receive a follow-up appointment, the primary care team (PCT) timely and properly notified the patient of the specialist's recommendations (MIT 1.008, 72.0%). For five patients, the record contained no evidence of either a PCP or RN appointment following a medium- and routine-priority specialty service or a generated patient letter communicating the specific specialist recommendations within our review period. For one patient, the primary care provider (PCP) follow-up appointment after a high-priority specialty service occurred five days late. For the remaining one patient, the record contained no evidence the patient completed a refusal form during our review period.
- The institution implemented a standardized process for the acquisition and submission of CDCR Forms 7362 for four of six housing units (MIT 1.101.2, 66.7%). For two housing units, custody staff did not have a supply of CDCR Forms 7362 available at the time of our inspection.

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

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

Analysis of Performance Across Inspection Cycles

Figure 1. Access to Care, Compliance Scores Across Cycles



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

SOL met the 75.0 percent passing compliance threshold in this indicator, maintaining an *adequate* performance of 79.9 percent in Cycle 8. While this score places SOL's performance well within the *adequate* range, this score follows SOL's previous *proficient* score of 92.0 percent in Cycle 6 and higher *adequate* score of 82.7 percent in Cycle 7. The current score represents some regression from previous cycles, indicating the institution's performance is trending closer to the minimum established standards for **Access to Care**.

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)	13	12	0	52.0%
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)	19	5	1	79.2%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	33	7	0	82.5%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	36	4	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)	15	2	23	88.2%
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)	2	0	38	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	15	2	0	88.2%
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)	18	7	8	72.0%
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)	4	2	0	66.7%
Overall percentage (MIT 1): 79.9%				

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

Compliance Recommendations

- Health care leadership should determine the challenges to facilitating timely chronic care follow-up appointments with providers, and provider follow-up appointments or notifications following specialty services appointments. 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 timely reviewed the results.

Case Review Ratings and Results Summary

In this cycle, case review found SOL performed satisfactorily with diagnostic services. Staff completed all onsite imaging studies and almost all laboratory tests timely. Providers also generally endorsed diagnostic records timely. However, providers need improvement in sending complete test result notification letters to patients. After considering all factors, the OIG rated the case review component of this indicator *adequate*.



Case Review Results

Table 7. Diagnostic Services Case Review Results

Diagnostic Events*	Deficiencies†	Significant Deficiencies‡
109	33	1

* The OIG reviewed 117 events.

† Deficiencies occurred in cases 8, 9, 11, 17–20, 23, 24, 32, 33, and 67. Of these 33 deficiencies, 32 related to health information management and one related to a delay in diagnostic test completion.

‡ A significant deficiency occurred in case 9.

Performed Well

OIG clinicians found SOL performed well in the following area:

- Test Completion²²

²² A minor deficiency occurred in case 9.

Performed Satisfactorily with Opportunities for Improvement

OIG clinicians found no areas in this indicator that SOL performed satisfactorily with opportunities for improvement.

Performed Poorly, Improvement Needed

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

- Health Information Management

OIG clinicians identified 32 deficiencies related to health information management, one of which was significant. Missing elements of the patient test result notification letters occurred 14 times. In addition, providers either did not send or sent the letters late in 12 occasions. We identified four late endorsements of test results and two delays in scanning.²³ The following is the one significant deficiency:

- In case 9, the patient underwent an ultrasound of the liver to assess for scar tissue or fibrosis; however, no provider endorsed the ultrasound result.

We also discuss Diagnostic health information management in the **Health Information Management** indicator.

Clinician On-Site Inspection

OIG clinicians met with the correctional health services administrator (CHSA) and the senior phlebotomist to discuss diagnostic processes at SOL. We also inspected the laboratory and radiology departments. The diagnostic services supervisor reported laboratory staff shortages, due to medical leave or staff working in out-of-class positions. The laboratory department had two full-time employee (FTE) vacancies while radiology was fully staffed at one FTE. Five phlebotomists worked at SOL and collected patient test blood samples in the CTC (correctional treatment center) and the RHU (restricted housing unit) at 6:30



Photo 1. Laboratory area for collecting test samples. Photographed on 7-29-2026.

²³ Late endorsements occurred in cases 9, 19, and 24. Two late scans occurred in case 32.

am as well as in general population (GP) at 7:00 am. One of the phlebotomists also functioned as a scheduler. The average number of blood draws fluctuated from 60 to nearly 100 per day. Staff reported the MAT program created an added workload, due to the high volume of testing.²⁴ Commonly ordered laboratory tests, apart from urine drug screens, included complete blood cell count, complete metabolic panel, lipid panel, and Hemoglobin A1c.²⁵

The radiologic technologist at SOL is responsible for performing all plain x-ray studies and the associated administrative duties. Outside imaging vendors for CT, MRI, and ultrasound are onsite at SOL every two weeks.²⁶ In addition to completing on-site studies, the radiologic technologist also uploads off-site radiology reports into the EHRS.²⁷ The technologist reports completing about 10-20 radiology studies in a day at SOL. The most commonly ordered plain radiology tests are x-rays of the chest, knee, ankle, and face after altercations. The radiologic technologist stated having an office technician (OT) would ease the workload burden.



Photo 2. Entrance to Radiology Room.
Photographed on 7-29-2026.



Photo 3. Radiology x-ray machine.
Photographed on 7-29-2026.

²⁴ MAT is the medication-assisted treatment program for substance use disorder.

²⁵ Hemoglobin A1c (HbA1c) is a blood test that measures the average plasma glucose over the previous 12 weeks. See <https://www.cdc.gov/diabetes/diabetes-testing/prediabetes-a1c-test.html>

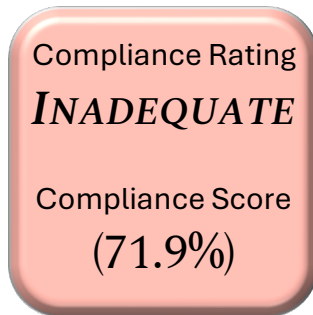
²⁶ A CT is a computed, or computerized, tomography scan while an MRI is a magnetic resonance imaging scan. Both create detailed images of the organs and tissues to detect diseases and abnormalities.

²⁷ EHRS is the department's Electronic Health Records System, which is used for storing the patient's medical history. The health care staff use the system to communicate. This record stays with the patient throughout the patient's time in department's correctional system.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

Diagnostic Services: Compliance Ratings and Results Summary



SOL exhibited opportunities for improvement in this indicator. Based on the overall compliance score result of 71.9 percent, the OIG rated the compliance component of this indicator *inadequate*.

Compliance Testing Results

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

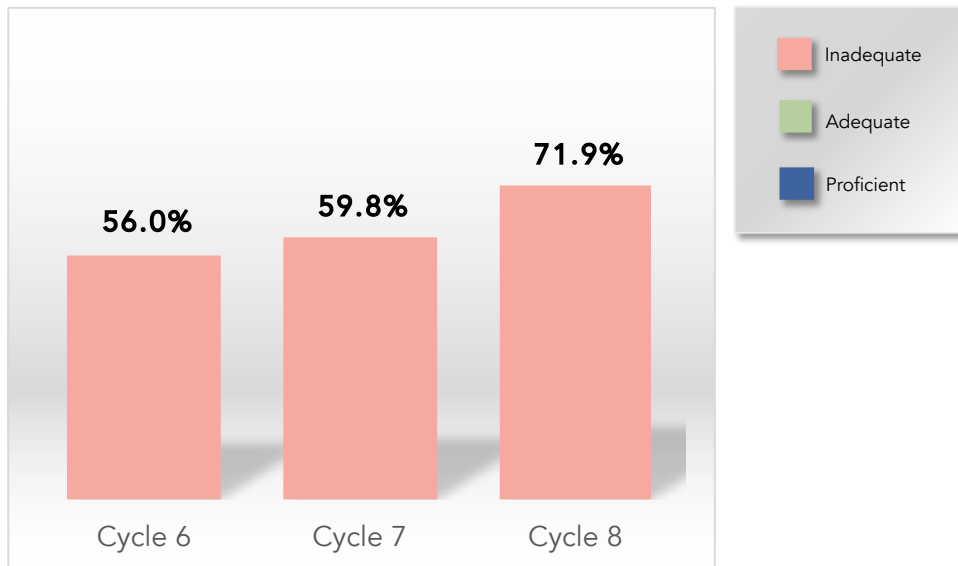
- The institution's radiology department delivered excellent diagnostic services for all 10 sampled patients within required time frames (MIT 2.001, 100%).
- Providers demonstrated proficiency in reviewing and endorsing radiology reports for nine of 10 sampled patients (MIT 2.002, 90.0%). For one patient, the provider reviewed and endorsed the result eight days late.
- Laboratory services consistently completed orders for nine of 10 sampled patients within the time frames specified (MIT 2.004, 90.0%). For one patient, the laboratory service ordered as a timed study was not performed within the specified time frames.
- Providers demonstrated proficiency in timely reviewing and endorsing laboratory reports for all 10 sampled patients (MIT 2.005, 100%).
- Healthcare providers generated patient notification letters for laboratory reports with all required elements within specified time frames for all 10 sampled patients (MIT 2.006, 100%).
- SOL received pathology reports for all 10 sampled patients within required time frames (MIT 2.010, 100%).
- Providers demonstrated proficiency in timely reviewing and endorsing pathology reports for all 10 sampled patients (MIT 2.011, 100%).

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

- Healthcare providers generated patient notification letters for radiology reports with all required elements within specified time frames for only three of 10 sampled patients (MIT 2.003, 30.0%). For five patients, the patient letters were missing key elements as required by policy. For one patient, the record contained no evidence of a generated patient letter communicating radiology results. For the remaining one patient, the provider communicated the result to the patient eight days late from the required time frame.
- The institution collected STAT (immediate) laboratory tests and received the results for three of six sampled patients within the required time frames (MIT 2.007, 50.0%). For three patients, the institution did not collect or receive the result timely.
- The provider acknowledged the STAT test results, or the nursing staff notified the provider of the STAT test results, within the required time frames for only one of six sampled patients (MIT 2.008, 16.7%). For five patients, the required notification or acknowledgment did not occur within the specified time frames.
- Providers demonstrated proficiency in endorsing STAT laboratory results for four of six sampled patients (MIT 2.009, 66.7%). For two patients, the provided did not timely endorse the result within the required time frame.
- Healthcare providers generated patient notification letters for pathology results with all required elements within the specified time frames for only two of 10 sampled patients (MIT 2.012, 20.0%). For five patients, the record contained no evidence of a generated patient letter communicating pathology results. For three patients, the patient letters were missing key elements as required by policy.

Analysis of Performance Across Inspection Cycles

Figure 2. Diagnostic Services, Compliance Scores Across Cycles



Source: OIG SOL 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 71.9 percent in Cycle 8. While this score remains in the *inadequate* performance range, this score demonstrates significant improvement over the past three cycles in this indicator, increasing from lower *inadequate* scores of 56.0 percent in Cycle 6 and 59.8 percent in Cycle 7, to a nearly *adequate* score in this cycle.

Table 8. Diagnostic Services Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? Effective 09/2025: Did the health care provider review and endorse the radiology report within specified time frames? (2.002)	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)	3	7	0	30.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the health care provider generate the patient notification letter with all the required elements within the specified time frame? (2.006)	10	0	0	100%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	3	3	0	50.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008)	1	5	0	16.7%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	4	2	0	66.7%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider generate the patient notification letter with all required elements within the specified time frame? (2.012)	2	8	0	20.0%
Overall percentage (MIT 2): 71.9%				

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

Compliance Recommendations

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

Emergency Services

In this indicator, OIG clinicians evaluated the quality of urgent and emergent medical care. Our clinicians reviewed these events by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) [and/or other emergency clinic, etc.] 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. Moreover, our clinicians evaluated the healthcare leadership's ability to identify opportunities for improvement in the emergency medical response review process.

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

Emergency Services: Case Review Ratings and Results Summary

In this cycle, case review found SOL provided sufficient emergency medical care. Medical staff and custody performed excellently in providing CPR. Nursing staff always responded promptly to medical emergencies and almost always activated emergency medical services (EMS) immediately. Nursing staff generally performed appropriate assessments and provided interventions as necessary. However, our clinicians identified opportunities for improvement in nursing assessments, interventions, and documentation as well as provider assessments and documentation. Additionally, SOL nursing and medical leadership completed clinical reviews for unscheduled transports including patient deaths; however, they did not always identify all the findings the OIG clinicians did. Out of the 12 significant deficiencies we identified, four related to clinical reviews, three related to provider performance, and five related to nursing performance. Considering all factors, the OIG rated this indicator *adequate*.

Case Review Rating
ADEQUATE

Case Review Results

Table 9. Emergency Services Case Review Results

Urgent or Emergent Events*	Deficiencies†	Significant Deficiencies‡
25	25	12

* The OIG clinicians reviewed 25 urgent or emergent events in 13 cases.

† Deficiencies occurred in cases 2, 7, 8, 19, 20, 24, and 69.

‡ Significant deficiencies occurred in cases 7, 8, 20, 24 and 69.

Performed Well

OIG clinicians found SOL performed well in the following area:

- CPR Quality²⁸

Performed Satisfactorily with Opportunities for Improvement

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

- Medical Emergency Response²⁹

OIG clinicians found SOL staff always responded promptly to emergency medical alarms and generally provided immediate interventions, including timely activating EMS and transporting the patient to the TTA. However, the following are significant findings:

- In case 8, the patient returned to SOL after discharging from the community hospital. He was treated for respiratory failure with pneumonia due to exacerbation of congestive heart failure and chronic obstructive pulmonary disease.³⁰ Custody staff transported the patient to SOL in a transportation van. The patient was prescribed an oxygen concentrator via nasal cannula with continuous oxygen. The TTA nurse informed the CTC nurse to deliver a nasal cannula to custody at the SOL entrance gate for the patient transport back to the institution. When the nurse arrived at the entrance gate, custody informed the

²⁸ CPR occurred in cases 4–7. Our OIG clinicians did not identify any deficiencies related to CPR.

²⁹ Medical emergency response deficiencies occurred in cases 2, 8, 20, and 69. Significant deficiencies occurred in cases 8 and 69.

³⁰ Congestive heart failure (CHF) is a condition in which the heart has difficulty pumping blood throughout the body. This can cause a collection of fluid in the lungs or other parts of the body leading to shortness of breath, swelling and fatigue. Chronic obstructive pulmonary disease (COPD) is a chronic and progressive lung disease that damages the lungs and makes breathing more difficult by blocking or limiting airflow in and out.

nurse the patient was in the transportation van experiencing trouble breathing. At 8:53pm, custody staff activated a medical emergency alarm. The nurse documented the mobile oxygen concentrator was empty and the transport van did not have a charging port. Per custody documentation, the patient could not be transported to CTC at that time due to weapons exchange hours. At 9:15pm, the patient arrived in CTC. These factors resulted in an approximately 20-minute delay in care while transporting the patient from the entrance gate to the CTC for care, during which time the patient did not have access to continuous oxygen and was struggling to breathe.

- In case 69, custody staff activated a medical emergency alarm for a patient with complaints of breathing problems. The TTA RN responded and transported the patient to the TTA. When the patient arrived at the TTA, he reported intermittent right sided, non-radiating moderate chest pain described as fluttering in the chest, dizziness, and increased pain when walking. The TTA RN performed an echocardiogram (EKG) showing abnormal results.³¹ The nurse administered aspirin and three doses of nitroglycerin, and the nurse started an IV.³² At 2:58pm, the nurse contacted the provider to give a report and received orders for a higher level of care transfer. However, the nurse delayed contacting EMS until 3:08pm, 10 minutes later. During the case review inspection, the institution agreed with our findings regarding this deficiency.
- Nursing Performance in Assessments and Interventions³³

OIG clinicians found nurses performed satisfactorily in nursing assessments and interventions. However, we found opportunities for improvement in assessments, reassessments, and interventions. The following is a significant finding:

- In case 20, the TTA RN assessed the patient for a medical emergency complaint of shortness of breath and documented the abdomen was distended and non-tender. However, the nurse did not assess the patient's bowel sounds, last meal, or last bowel movement. Additionally, the nurse administered two nebulizer treatments but did not reassess the patient's lung sounds or document administering the treatments on the medication administration record. Further, the patient's oxygen saturation rate was low, at 93 percent on room air, after the nurse administered two respiratory treatments; however, the nurse did not notify

³¹ An EKG is an electrocardiogram, a non-invasive test measuring and recording the electrical impulses from the heart used to help diagnose heart problems.

³² Nitroglycerin is a medication that dilates blood vessels to increase blood flow to the heart. Nitroglycerin may be used to relieve chest pain because, when blood vessels dilate, this decreases the amount of work for the heart, which can result in a drop in blood pressure.

³³ Nursing performance assessments and intervention deficiencies occurred in cases 7, 8, 19, 20, and 69. Significant deficiencies occurred in cases 7, 8, and 20.

the provider of the low oxygenation saturation rate. Instead, the nurse released the patient back to the housing.

- Nursing Performance in Documentation³⁴

OIG clinicians found SOL nurses generally documented appropriate nursing care, including timelines for emergency events. We identified four minor documentation deficiencies, which did not impact overall patient care.

- Emergency Medical Response Review Process³⁵

OIG clinicians found SOL performed timely clinical reviews for emergency medical responses in which patients transferred to a higher level of care, including patient deaths. However, we found medical leadership did not always identify the same opportunities for improvement our OIG clinicians identified.

- Provider Performance³⁶

SOL providers usually diagnosed patients accurately, documented completely, and made sound triage and treatment decisions for TTA patients. OIG clinicians identified five deficiencies, three of which were significant. We discuss provider performance in the emergency setting further in the **Provider Performance** indicator.

Performed Poorly, Improvement Needed

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

³⁴ Nursing documentation deficiencies occurred in cases 19, 20, and 69. No significant deficiencies occurred.

³⁵ Deficiencies occurred in cases 2, 8, 19, and 69. Significant deficiencies occurred in cases 8 and 69.

³⁶ Provider performance deficiencies occurred in cases 20, 24, and 69. Significant deficiencies occurred in cases 24 and 69.

Clinician On-Site Inspection

During the on-site inspections, OIG clinicians inspected and interviewed TTA nursing staff. The TTA had three examinations rooms, one observation room, and three medical response vehicles. TTA staffing consisted of two RNs per shift, and if available, a float nurse would also be assigned. TTA nurses responded to any area of the institution. On the yards, LVN staff responded to emergency calls, and then called for TTA RNs if further care was required. The TTA did not have an assigned provider; instead, a different provider covered the TTA and CTC daily. After hours, staff contacted the on-call provider for any issues.



Photo 4. TTA Examination Rooms.
Photographed on 7-29-2026.



Photo 5. TTA Medical Response Vehicles.
Photographed on 7-29-2026.

Aside from responding to emergencies, SOL TTA nurses had various duties assigned. During night shift, nursing staff were responsible for picking up sick call requests from the yards daily. Day shift nursing staff triaged sick call requests. On the weekends, TTA night shift nurses picked up sick call requests and were responsible for triaging, scanning, and scheduling any patients who needed to be seen urgently. TTA nurses are also responsible for assessing patients arriving after a hospital admission or hospital encounter. When patients return from a hospital encounter, staff contacted the provider for orders, if any are required. TTA nursing staff stated, if a patient arrives without discharge paperwork, they will not call the hospital to obtain the paperwork since normally the discharge paperwork is faxed to TTA. The utilization management nurse will obtain the discharge paperwork as well. In addition, the PCP to hospital physician handoff also occurs prior to the patient's discharge back to the institution, so

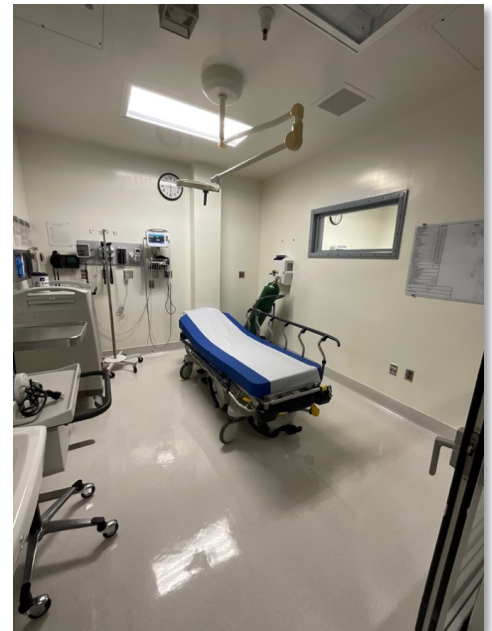


Photo 6. TTA Examination Room.
Photographed on 7-30-2026.

the PCP will be aware of any orders or needs the patient has after discharge. Overall, TTA nursing staff reported they feel supported by their leadership and custody partners.

Case Review Recommendations

- Nursing leadership should determine the challenges to nurses performing thorough assessments, interventions, and reassessments of emergent and urgent conditions. Leadership should implement and monitor remedial measures as appropriate.

Emergency Services: Compliance Ratings and Results Summary

Compliance Rating

INADEQUATE

Compliance Score

(59.7%)

SOL needed improvement in this indicator, as most of the institution's results were consistently lacking and fell significantly below the testing threshold. Based on the overall compliance score of 59.7 percent, the OIG rated the compliance component of this indicator **inadequate**.

Compliance Testing Results

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

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

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

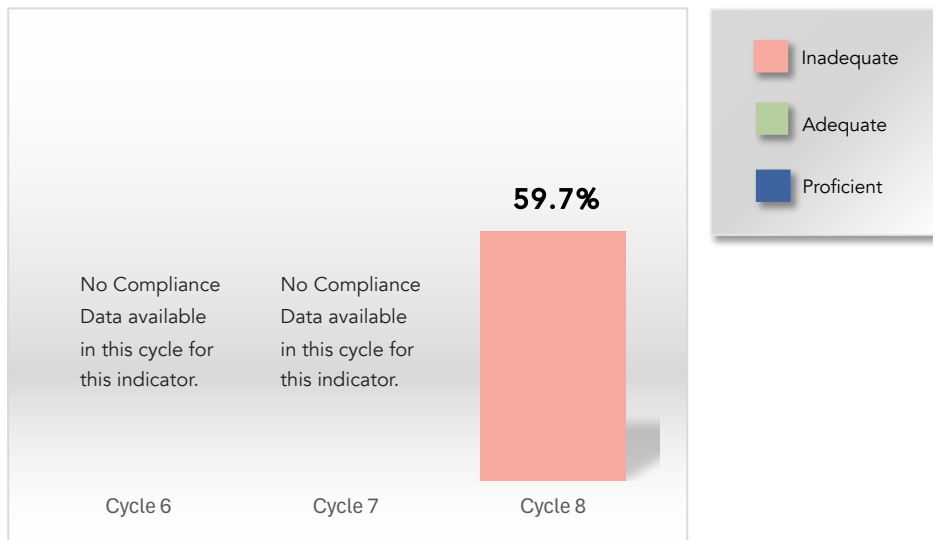
- The Emergency Medical Response Review Committee (EMRRC) reviewed cases in a timely manner and ensured incident packages included all required documents for only three of 12 sampled patients (MIT 3.001, 25.0%). For nine patients, we found one or both of the following deficiencies: the institution did not review the cases timely or the emergency medical response review event checklists were incomplete.
- Nursing staff inspected and inventoried emergency medical response bags (EMRBs) and ensured they contained all essential items for four of the six applicable clinical areas (MIT 3.101, 66.7%). For two EMRBs, staff had not inventoried the EMRBs when seal tags were replaced (see Photo 7, right).

Photo 7. Incomplete EMRB checklist log. Photographed on 6-15-2026.

- Photo 8. Incomplete treatment cart seal security check log documentation.
Photographed on 6-16-2026.

Analysis of Performance Across Inspection Cycles

Figure 3. Emergency Services, Compliance Scores Across Cycles



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

The institution performed below established standards for emergency response and coordination, highlighting a significant need for improvement in this indicator. Specifically, the institution did not meet the 75.0 percent passing compliance threshold for emergency readiness and performance evaluation, reaching only 59.7 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, and continuing *inadequate* scores in the remaining tests. However, among the *inadequate* scores, the trends show improvement in MIT 3.001, significant improvement in MITs 3.101 and 3.104, and regression in MIT 3.102.

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	0.0%	8.3%	25.0%
MIT 3.101 & 3.102	0.0%	14.3%	MIT 3.101 66.7% MIT 3.102 0.0%
MIT 3.104	0.0%	0.0%	66.7%
MIT 3.105	100%	100%	100%

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

Table 11. Emergency Services Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the case timely, and did the incident packages reviewed include the required documents? (3.001)	3	9	0	25.0%
Clinical areas: Are emergency medical response bags inspected and inventoried within required timeframes, and do they contain essential items? (3.101)	4	2	10	66.7%
Clinical areas: Are treatment carts inspected and inventoried within required timeframes? (3.102)	0	2	14	0
Clinical areas: Are disaster response bags inspected and inventoried within required timeframes? (3.103)	1	0	15	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)	2	1	0	66.7%
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%

Source: The Office of the Inspector General medical inspection results available here: www.oig.ca.gov. Overall percentage (MIT 3): **59.7%**

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 treatment carts in accordance with CCHCS policy.

Health Information Management

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

Case Review Ratings and Results Summary

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



Case Review Results

Table 12. HIM Case Review Results

Events*	Deficiencies†	Significant Deficiencies‡
807	47	3

* The OIG reviewed 807 events.

† Deficiencies occurred in cases 8, 9, 11, 15, 17-20, 22-24, 31-33, 67, and 69. Of these 47 deficiencies, 32 related to diagnostic reports, 13 related to specialty reports, and two related to scanning performance.

‡ Significant deficiencies occurred in cases 9, 15, and 23.

Performed Well

OIG clinicians found SOL performed well in the following areas:

- Hospital Records³⁷
- Urgent and Emergent Records³⁸
- Scanning Performance³⁹

Performed Satisfactorily with Opportunities for Improvement

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

- Specialty Reports

SOL generally retrieved and scanned specialty reports timely; however, OIG clinicians identified one missing report, six reports scanned late, and one mislabeled report.⁴⁰ The following are examples:

- In case 15, SOL staff scanned the audiology specialty report two weeks late.
- In case 23, SOL staff scanned the dermatology specialty report two days late.

SOL providers generally endorsed specialty reports timely and informed patient of specialty results; however, OIG clinicians identified one missing endorsement, three late endorsements, and one missing notification letter.⁴¹

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

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

³⁹ Two scanning deficiencies occurred in cases 8 and 20. In case 8, the deficiency related to a mislabeled report, and in case 20, to a duplicate scan.

⁴⁰ A missing specialty report occurred in case 24. Untimely scanned specialty reports occurred in cases 9, 15, 22, 23, and 69. A mislabeled report occurred in case 23.

⁴¹ A missed endorsement occurred in case 31. Late endorsements occurred in cases 8 and 23. A missing notification letter occurred in case 22.

Performed Poorly, Improvement Needed

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

- Diagnostic Reports

SOL generally retrieved and scanned diagnostic reports timely; however, OIG clinicians identified late-scanned reports.⁴² The following is an example:

- In case 32, medical staff scanned an EKG report two days late.

SOL providers generally endorsed diagnostic reports timely; however, OIG clinicians identified two missed endorsements and two late endorsements.⁴³ The following are examples:

- In case 19, the provider endorsed an x-ray report nine days late.
- In case 24, the provider did not endorse an EKG report.

SOL providers performed poorly in communicating diagnostic results to their patients. OIG clinicians identified seven missing test result notification letters and four late notification letters.⁴⁴ The following are examples:

- In case 8, the provider endorsed the laboratory test results but did not generate a patient test result notification letter.
- In case 11, the provider endorsed the laboratory test results but sent a patient notification letter three weeks late.

SOL providers also did not consistently send complete patient test result notification letters with all the required elements.⁴⁵ The following are examples:

- In case 11, the provider sent a patient notification letter, which did not include date of the tests and whether a follow-up appointment was needed.
- In case 17, the provider sent a patient notification letter, which did not include whether the results were unchanged, within normal limits, or as expected.

⁴² Staff scanned diagnostic reports late in case 32.

⁴³ Two missed endorsements occurred in cases 9 and 24. Two late endorsements occurred in cases 9 and 19.

⁴⁴ Seven missing notification letters occurred in cases 8, 11, 24, 32, and 33. Four late notification letters occurred in case 11.

⁴⁵ Fifteen incomplete notification letters occurred in cases 11, 17, 18, 20, 23, 24, 33, and 67.

We also discuss management of diagnostic health information in the **Diagnostics** indicator.

Clinician On-Site Inspection

The OIG clinicians inspected the HIM department and met with the health records technician (HRT) supervisor and acting HRT I to discuss management of health information records. HIM leadership reported having a full time employee (FTE) staff shortage of 0.90 HRTs and 2.80 office assistants (OA). Additionally, at the time of the onsite inspection, HIM leadership reported one HRT team member had passed away, and they had no current plans to fill this vacant HRT position.

To track off-site specialty services and hospitalizations, HIM leadership reported using a tracking log with an Excel spreadsheet. Only HIM staff has access to this tracking log. To obtain the outside medical records, HIM staff sent faxes to the corresponding hospital or off-site specialty service offices. When possible, HIM staff also emailed off-site specialty service offices to request records. HIM staff then updated the tracking log and compare SOL's census with the records received daily. HIM leadership stated off-site specialty staff do not always respond timely to HIM's requests. Additionally, staff turnover at the off-site specialty clinics sometimes added to difficulties in obtaining records timely because new staff were not always aware of the time frame requirements to obtain medical records. For on-site specialty service records, staff collected the records from each clinic and scanned them into EHRS on the same day. HIM staff did not track on-site records due to limited staffing.



Photo 9. Documents identified for sorting and scanning in the HIM department.
Photographed on 7-29-2026.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

Health Information Management: Compliance Ratings and Results Summary



In this indicator, SOL performed very well with timely scanning specialty reports and correctly labeling documents. Based on the overall compliance score result of 87.3 percent, the OIG rated the compliance component of this indicator **proficient**.

Compliance Testing Results

SOL 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 Forms 7362) into the electronic health record system (EHRS). Staff scanned all documented forms within the required timeframes, ensuring immediate data availability for the patient care team (MIT 4.001, 100%).
- The institution ensured staff scanned specialty notes into the patients' EHRS in accordance with established timelines for 19 of 22 applicable sampled patients (MIT 4.002, 86.4%). For three patients, staff scanned the specialty reports between two and five days late.
- The institution labeled and scanned records into the patients' EHRS for 22 of the 25 sampled patients (MIT 4.004, 88.0%). For three patients, we found one or more of the following deficiencies: the documents were either mislabeled or missing during our review period.

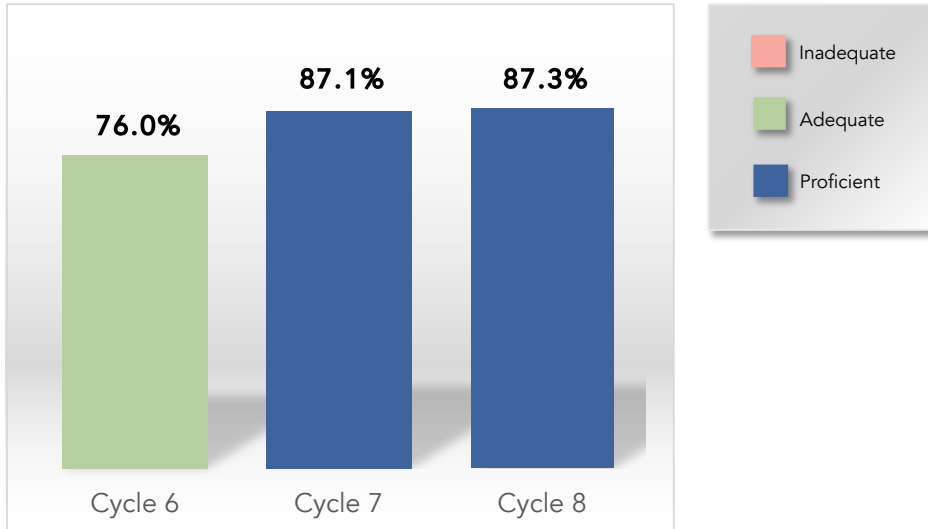
SOL performed in the **adequate** range in the following sub-indicators:

- The institution demonstrated sufficient operational performance ensuring community hospital discharge documents were scanned into the patients' EHRS within required time frames for 12 of 15 sampled patients (MIT 4.003, 80.0%). For three patients, staff scanned the reports between one and 30 days late.
- The institution exhibited adequacy in ensuring the provider reviewed and endorsed community hospital discharge reports within five calendar days of discharge for 14 of 17 sampled patients (MIT 4.005, 82.4%). For two patients, the record contained no evidence

the institution received the hospital discharge report. For the remaining one patient, the provider reviewed the report 28 days late.

Analysis of Performance Across Inspection Cycles

Figure 4. Health Information Management, Compliance Scores Across Cycles



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

In Cycle 8, SOL's performance exceeded the 75.0 percent passing compliance threshold for **Health Information Management (HIM)**, reaching 87.3 percent in Cycle 8. This score follows SOL's *adequate* performance result of 76.0 percent in Cycle 6 and *proficient* performance result of 87.1 percent in Cycle 7. The current score represents a steady progression from previous cycles, indicating the institution's performance is continually improving and trending further above the minimum established standards for **HIM**.

Table 13. Health Information Management Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within one calendar day of the patient encounter date? (4.001)	20	0	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	19	3	11	86.4%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	12	3	2	80.0%
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)	14	3	0	82.4%
Overall percentage (MIT 4): 87.3%				

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

Compliance Recommendations

The OIG offers no compliance recommendations for this indicator.

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



SOL performed exceptionally during this inspection cycle. Based on the overall compliance score result of 96.8 percent, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Testing Results

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

- The institution demonstrated very good performance in maintaining a clean and sanitary environment for all 16 clinical health care areas (MIT 5.101.2, 100%).
- The institution demonstrated excellent performance in ensuring staff consistently updated the corresponding cleaning logs for all 16 clinics (MIT 5.101.3, 100%).
- The institution ensured reusable non-invasive medical equipment was properly disinfected as warranted for all nine applicable clinical health care areas (MIT 5.102.2, 100%).

- All 15 applicable clinics ensured clinical health care areas contained operable sinks and sufficient quantities of hygiene supplies (MIT 5.103, 100%).
- The institution attained perfect performance in ensuring clinical health care areas controlled exposure to blood-borne pathogens and contaminated waste for all 12 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%).
- All 16 clinics ensured adequate management and storage of bulk medical supplies (MIT 5.107, 100%).
- The institution sustained outstanding performance in ensuring the environments in the common clinical for all seven applicable clinics and nonclinical areas are conducive to providing medical services for all six applicable clinics (MIT 5.109.1, 100%, and MIT 5.109.2, 100%).
- The institution upheld superior performance in ensuring the clinic exam rooms have adequate space and remain free of clutter to provide medical services for all 12 applicable clinics (MIT 5.110.1, 100%, and MIT 5.110.2, 100%).
- All 12 applicable clinic exam rooms were equipped with working computer stations, well-maintained furniture, and accessible medical equipment (MIT 5.110.3, 100%). Furthermore, all clinic exam rooms allowed for privacy and confidentiality when providing medical services (MIT 5.110.4, 100%).

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

- Thirteen of 16 clinics ensured common areas and exam rooms were equipped with essential core medical equipment and supplies (MIT 5.108.2, 81.3%). In three clinics, we found one or more of the following deficiencies: defibrillator test performance was found incomplete; ophthalmoscope was non-functional; and an exam room was missing lubricating jelly.

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

- Seven of 10 medical staff observed adhered to universal hand hygiene precaution, in which staff follows proper handwashing protocols (MIT 5.104, 70.0%). During three observations of medical exams, medical staff members failed to wash or sanitize their hands before and after physically touching the patient.

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

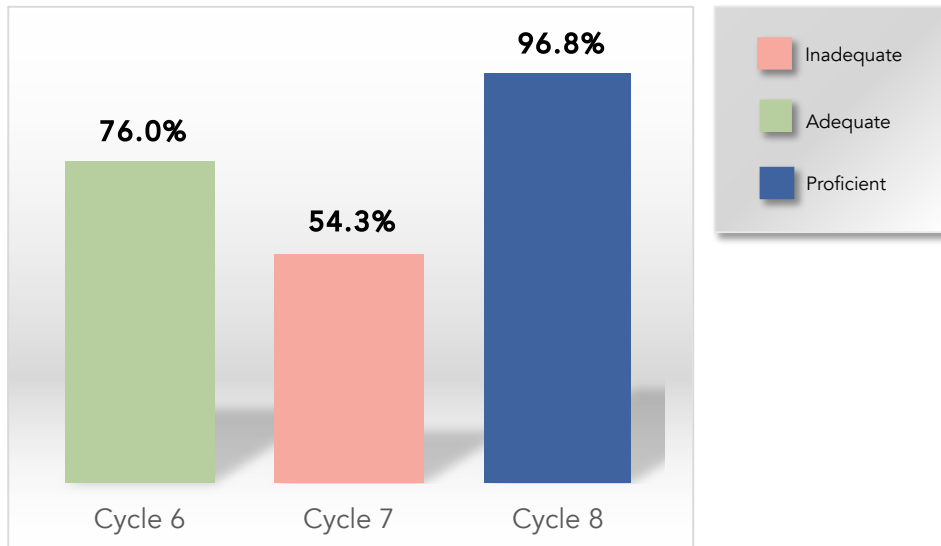
- Cleaning staff managed by California Correctional Training and Rehabilitation Authority (CALCTRA) formerly known as California Prison Industry Authority (CALPIA) and SOL clinical staff did not express concerns regarding the maintenance of infection control and prevention within the clinical health care areas (MIT 5.101.1, N/A). The facility maintained a standardized cleaning process utilizing hospital-grade chemical disinfectants specifically intended for clinical environments.
- We deemed the compliance test for MIT 5.102.1 in this indicator not applicable during this inspection cycle as no sterilization or chemical cleaning procedures are conducted at this institution (MIT 5.102.1, N/A).
- The facility demonstrated excellent equipment oversight, maintaining an uninterrupted inventory of clinical supplies and ensuring essential equipment remained in proper working order (MIT 5.108.1, N/A).
- We inspected indoor patient waiting areas and found, while the majority of the clinic waiting areas provided sufficient seating capacity, the TTA waiting area was problematic (see Photo 10, right). Staff reported this particular clinical area did not have an appropriately sized waiting area with sufficient seating for patients waiting for their clinical appointments. According to custody staff, during high-traffic movements, patients are waiting in both the TTA and clinic hallways. Although an appropriately sized waiting area is physically available for this location, it remains unused because the necessary custody officer post is unfunded (MIT 5.109.2, N/A).
- At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999, N/A).



Photo 10. Insufficient waiting area in TTA.
Photographed on 06-16-2026.

Analysis of Performance Across Inspection Cycles

Figure 5. Health Care Environment, Compliance Scores Across Cycles



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

In Cycle 8, SOL performed exceptionally in the **Health Care Environment** category, achieving a high *proficient* score of 96.8 percent. This rating demonstrates a significant recovery following an *adequate* rating of 76.0 percent in Cycle 6 and subsequent regression to an *inadequate* rating of 54.3 percent in Cycle 7, indicating strong and successful progress toward significantly exceeding established benchmarks in this area.

Table 14. Health Care Environment Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For informational purposes only: Did the clinical health care staff report any concerns with maintaining infection control? (5.101.1)	0	0	16	N/A
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101.2)	16	0	0	100%
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)	16	0	0	100%
Infection control: Do clinical health care areas ensure that reusable invasive medical equipment is properly sterilized or disinfected as warranted? (5.102.1)	0	0	16	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)	9	0	7	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	15	0	1	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	7	3	6	70.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	12	0	4	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)	16	0	0	100%
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	16	N/A
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108.2)	13	3	0	81.3%
Clinical areas: Are the environments in the common clinical areas conducive to providing medical services? (5.109.1)	7	0	9	100%
Clinical areas: Are the environments in the common non-clinical areas conducive to providing medical services? (5.109.2)	6	0	10	100%
Clinical areas: Do the clinic exam rooms have adequate space to provide medical services? (5.110.1)	12	0	4	100%
Clinical areas: Are the clinic exam rooms free of clutter and conducive to providing medical services? (5.110.2)	12	0	4	100%
Clinical areas: Do clinic exam rooms have working computer stations and well-maintained furniture and accessible medical equipment? (5.110.3)	12	0	4	100%
Clinical areas: Do clinic exam rooms allow for privacy and confidentiality when providing medical services? (5.110.4)	12	0	4	100%
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): 96.8%				

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 left. 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 SOL performed sufficiently in the transfer process. The nurses screened patients appropriately who transferred into the institution and scheduled provider follow-up appointments as required. During the transfer out process the nurses almost always ensured all requirements were met. When patients returned from a hospitalization, the nurses generally performed appropriate assessments. However, sometimes the nurses' assessments were incomplete. Considering all factors, the OIG rated the case review component of this indicator *adequate*.

Case Review Rating

ADEQUATE

Case Review Results

Table 15. Transfers Case Review Results

Transfer Events*	Deficiencies†	Significant Deficiencies‡
34	10	1

* The OIG clinicians reviewed 44 events in 21 cases in which patients transferred into or out of the institution and 10 events in which patients returned from an off-site hospital or emergency room.

† Deficiencies occurred in cases 2, 3, 8, 19, 21, 25, 28, 30, and 69.

‡ Significant deficiencies occurred in case 19.

Performed Well

OIG clinicians found SOL performed well in the following areas:

- Transfers In⁴⁶
- Transfers Out⁴⁷

Performed Satisfactorily with Opportunities for Improvement

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

- Hospital Returns⁴⁸

OIG clinicians found nurses performed assessments upon patients' returns from the community hospitals and emergency rooms; however, nurses intermittently did not perform complete assessments. We also found patients returning from the community hospitals almost always received their medications without interruption. The following are significant deficiencies:

- In case 3, the nurse assessed the patient after a community hospital admission for weakness of the right leg and a mini stroke. However, the nurse did not assess the patient's extremity strength and range of motion; the steadiness of the patient's gait; or the patient's abdomen, urinary system, and behavioral health symptoms.

⁴⁶ OIG clinicians reviewed 13 transfer-in events in cases 1, 7, 25–27, 31, and 34. A transfer-in deficiency occurred in case 25 but was not significant.

⁴⁷ OIG clinicians reviewed eight transfer-out events in cases 2 and 28–30. Transfer-out deficiencies occurred in cases 28 and 30, none of which were significant.

⁴⁸ OIG clinicians reviewed 10 hospital return events in cases 2, 3, 8, 19–21, 32, 33, and 69. Hospital return deficiencies occurred in cases 2, 3, 8, 19, 21, and 69. One significant deficiency occurred in case 19.

- In case 19, the patient returned from a hospitalization for kidney stone treatment resulting in stent placement. The provider ordered a new medication to treat gastric reflux. However, the patient did not receive the medication until almost a month later.

Performed Poorly, Improvement Needed

OIG clinicians found no areas with which SOL performed poorly.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians inspected the receiving and release (R&R) area. The R&R was staffed with one RN on each of the three shifts, excluding weekends and holidays. We interviewed the R&R RN, who was knowledgeable regarding the transfers process. The nurses indicated they communicated with providers to discuss any pending upcoming specialty services appointments for patients scheduled to transfer out of SOL. For patients transferring into SOL, they communicated with providers to reconcile any orders and follow-up appointments as needed.

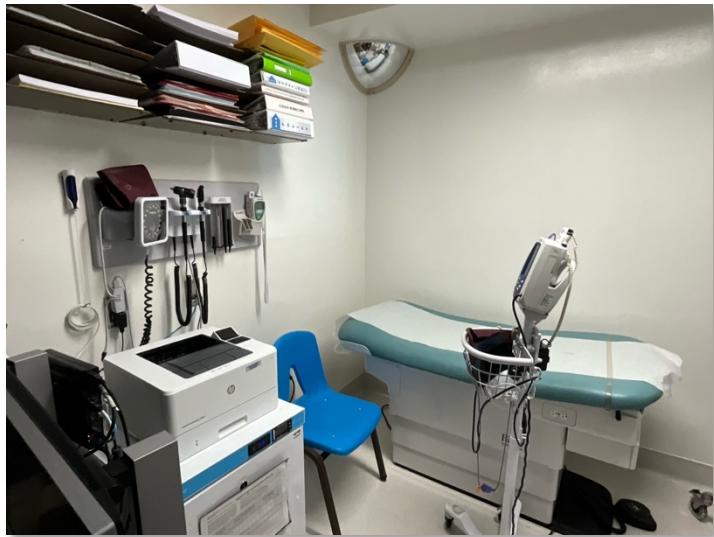


Photo 11. Receiving and Release RN Exam Room.
Photographed on 7-30-2026.

The R&R RN and the pharmacist both reported that naloxone was available in the R&R area to dispense to patients who have an active order for naloxone, so they can keep the medication on their person during the transport.⁴⁹ The naloxone was stored in the medication cart within the R&R nursing examination room, along with other rescue and keep-on-person medications.⁵⁰

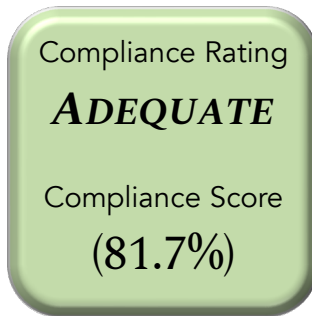
⁴⁹ Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose. According to the manufacturer, nasal naloxone doses can be safely administered every two to three minutes. CCHCS emergency medical training allows nurses to administer five nasal naloxone doses when an opioid overdose is suspected.

⁵⁰ Keep-on-person or KOP medications are medications that a patient can keep and self-administer according to the directions provided.

Case Review Recommendations

- Nursing leadership should develop strategies to ensure nurses thoroughly complete assessments for patients returning from the hospital or emergency room. Leadership should implement and monitor remedial measures as appropriate.

Transfers: Compliance Ratings and Results Summary



SOL demonstrated very good performance for this indicator. Based on the overall compliance score result of 81.7 percent, the OIG rated the compliance component of this indicator *adequate*.

Compliance Testing Results

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

- Nursing staff showed sufficient performance in completing the assessment and disposition sections of the initial health screening form for all 23 applicable sampled patients (MIT 6.002, 100%).

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

- Nursing staff completed initial health screenings and answered all screening questions within the required time frame for 21 of 25 sampled patients (MIT 6.001, 84.0%). For four patients, nursing staff failed to document a complete set of vitals and weight measurements during screening process.

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

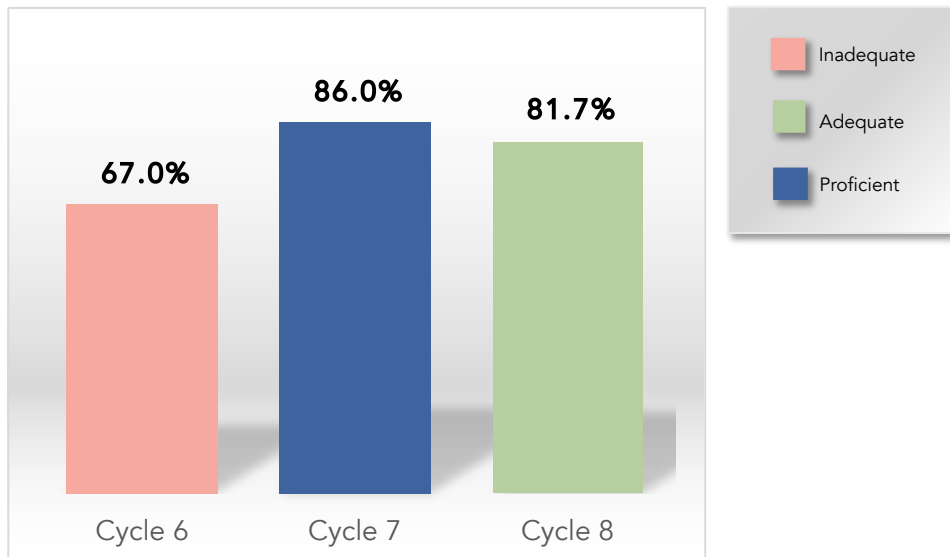
- Nursing staff ensured medications were administered or delivered without interruption for only six of 14 applicable sampled patients (MIT 6.003, 42.9%). For eight patients, we found one or both of the following deficiencies: incomplete documentation of the patient's stated reason for refusing medication or incomplete documentation of the patient's stated reason for not presenting to the medication line.

Compliance On-Site Inspection and Discussion

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

Analysis of Performance Across Inspection Cycles

Figure 6. Transfers, Compliance Scores Across Cycles



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

In Cycle 8, SOL performed well in the Transfers indicator, achieving an *adequate* score of 81.7 percent. While this score represents a slight decline from the institution's previous *proficient* rating of 86.0 percent in Cycle 7, it maintains a stable upward trend from the *inadequate* performance of 67.0 percent in Cycle 6, indicating the institution has continued to meet minimum established standards for this indicator.

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)	21	4	0	84.0%
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	0	2	100%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or issued without interruption? (6.003)	6	8	11	42.9%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	3	0	0	100%
Overall percentage (MIT 6): 81.7%				

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

Compliance Recommendations

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

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 SOL provided overall satisfactory medication management. Our clinicians found the institution performed well in medication continuity for patients who transferred in and out of the institution as well as patients returning from the hospital or emergency room. Although our clinicians identified very few significant deficiencies, we found opportunities for improvement in ensuring patients received their newly prescribed medications, chronic care medications, and specialized medical housing medications without interruption. Considering all factors, the OIG rated the case review component of this indicator *adequate*.



Case Review Results

Table 17. Medication Management Case Review Results

Medication Events*	Deficiencies†	Significant Deficiencies‡
162	18	9

* The OIG clinicians reviewed 162 events in 34 cases related to medications.

† Deficiencies occurred in cases 1-3, 14, 15, 17, 19, 21, 24, 32-34, and 68.

‡ Significant deficiencies occurred in cases 2, 14, 17, 19, 24, and 33.

Performed Well

OIG clinicians found SOL performed well in the following areas:

- Transfer Medications⁵¹
- Hospital Discharge Medications⁵²

Performed Satisfactorily with Opportunities for Improvement

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

- Newly Prescribed Medications⁵³

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

- In case 24, in December 2025, the patient did not receive the colon prep medication prior to a scheduled colonoscopy; therefore, the patient had to be rescheduled for a colonoscopy. During the case review inspection, the institution agreed with our findings regarding this deficiency.
- On another occasion in case 24, during the month of February 2026, the patient did not always receive the oral cancer treatment medication as ordered. During the case review inspection, the institution agreed with our findings regarding this deficiency.
- Chronic Medications⁵⁴

OIG clinicians found most patients with chronic care conditions received their medications timely. However, OIG clinicians identified the following patterns: in a few cases patients received ordered keep on person (KOP) medications twice in one month and other patients did not always receive their ordered medications timely or at all.⁵⁵ The following are examples:

⁵¹ No transfer-in or transfer-out medication deficiencies occurred.

⁵² A hospital discharge medication deficiency occurred in case 19, which was significant.

⁵³ Newly prescribed medication deficiencies occurred in cases 1, 3, and 24. Significant deficiencies occurred in case 24.

⁵⁴ Chronic care medication deficiencies occurred in cases 1, 2, 14, 15, 17, 21, and 68. Significant deficiencies occurred in cases 2, 14, and 17.

⁵⁵ KOP means “keep on person” and refers to medications that a patient can keep and self-administer according to the directions provided.

- In case 14, on March 21, 2026, the patient was due to receive the KOP chronic care diabetic medication semaglutide. However, the patient did not receive the medication. During the case review inspection, the institution agreed with our findings regarding this deficiency.
- In case 21, during the month of February 2026, the patient received two 30-day supplies of multiple blood pressure medications: amlodipine, hydrochlorothiazide, and lisinopril. During the case review inspection, the institution agreed with our findings regarding this deficiency.
- Specialized Medical Housing (SMH) Medications⁵⁶

For SMH medication management, OIG clinicians found SMH generally provided medications timely. We identified three significant deficiencies in one case and identified the following opportunities for improvement:

- In case 33, on July 8, 2025, the patient returned to CTC from the hospital with a discharge diagnosis of vision changes and vision loss. The patient stated his right eye was “ok,” but his left eye was blurry. The RN completed the admission assessment and history, and the provider reconciled the hospital medications. However, the patient did not receive the scheduled evening dose of medications, including two seizure medications and one medication to treat resting tremors.⁵⁷
- Additionally, in case 33, nursing staff did not consistently adhere to prescribed blood pressure parameters for the resting tremor medication between July and August, which can cause a further drop in the patient’s blood pressure. During the case review inspection, the institution agreed with our findings regarding this deficiency.
- In case 34, from September to October 2025, the patient did not always receive the scheduled evening dose of medication to treat prostate enlargement.

Performed Poorly, Improvement Needed

OIG clinicians found no areas with which SOL performed poorly.

⁵⁶ Specialized medical housing medication deficiencies occurred in cases 32–34. Significant deficiencies occurred in case 33.

⁵⁷ Resting tremors is an involuntary rhythmic shaking of a body part, most commonly a hand or finger, that occurs when a patient’s muscles are completely relaxed and resting, but which often improves or stops when they actively move.

Clinician On-Site Inspection

The medication administration areas at SOL are located on the various yards but notably away from the central health clinics (CHC). During the on-site inspection, OIG clinicians inspected the medication administration area in D Yard. The medication administration room was clean and well organized. Three LVNs were on duty: two LVNs administered medications at the medication windows and one LVN administered injections. The LVNs reported they were also responsible for responding to medical emergencies on the yards. The LVNs reported they did not attend the morning huddles; however, they communicated medication concerns via the Cerner messaging system directly to the provider or the care team. The LVNs were knowledgeable regarding the medication process.



Photo 12. Pharmacy Controlled Substances. Photographed on 7-30-2026.

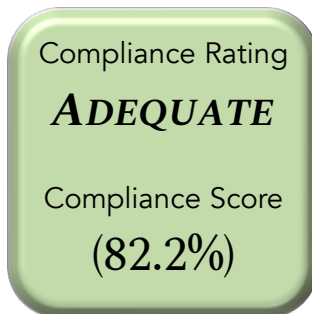
During our visit, the clinic care team staff reported having a high rate of Suboxone refusals and formed a refusal work group to identify barriers for patients refusing Suboxone.⁵⁸ SOL staff identified peer pressure as a deterrent to Suboxone compliance. The current statewide Suboxone administration process requires all patients taking this medication to remain at the medication window for 30 seconds to ensure the medication is absorbed thoroughly in their mouth. SOL staff found this step allowed other inmates to adversely identify patients taking Suboxone to treat opioid dependence. In April 2025, CCHCS headquarters granted SOL permission to enact a pilot project in which SOL eliminated the 30-second wait time, and SOL staff indicated removing this step initially increased Suboxone compliance. The clinic care team staff also reported they were considering supportive housing for patients taking Suboxone to further increase compliance.

⁵⁸ Suboxone is a medication containing buprenorphine and naloxone, which is used to treat opioid dependence and addiction.

Case Review Recommendations

- Health care leadership should develop strategies to ensure chronic care and specialized medical housing medications are made available and administered to the patients without interruptions. Leadership should implement and monitor remedial measures as appropriate.
- The department should develop, implement, and monitor strategies, such as a monitoring system in the EHRS to identify reasons for patient safety concerns to prevent staff from administering duplicate medications.

Medication Management: Compliance Ratings and Results Summary



SOL performed satisfactorily in this indicator. Based on the overall compliance score result of 82.2 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- The institution showed proficiency in making new order prescription medications available to patients within the required timeframes for 21 of 22 applicable sampled patients (MIT 7.002.1, 95.5%). For one patient, the pharmacy did not make newly ordered medications available to the patient within the required timeframe.
- The institution administered or issued new order prescription medications within required time frames for all 25 sampled patients (MIT 7.002.2, 100%).
- The provider ordered post-hospitalization medication orders within the required time frames for all 17 applicable sampled patients (MIT 7.003.1, 100%).
- The institution administered or delivered medications without interruption to patients laying over at SOL for nine of 10 sampled patients (MIT 7.006, 90.0%). For one patient, nursing staff failed to completely document the patient's stated reason for refusing medications.
- The institution adequately stored and secured narcotic medications for all eight applicable clinic and medication line locations (MIT 7.101, 100%).
- The institution appropriately stored and secured non-narcotic medications in eight of nine applicable clinic and medication line locations (MIT 7.102, 88.9%). In one location, the medication area lacked a clearly labeled designated area for refrigerated medications to be returned to the pharmacy.
- Staff kept medications protected from physical, chemical, and temperature contamination in all nine applicable clinic and medication line locations (MIT 7.103, 100%).

- Staff successfully stored valid, unexpired medications in all nine applicable medication line locations (MIT 7.104, 100%).
- Staff in all five applicable medication preparation and administration areas showed appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 100%).
- Staff in six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 100%).
- SOL pharmacy followed general security, organization, and cleanliness management protocols in its main pharmacy (MIT 7.108, 100%).
- SOL 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%).
- We examined 25 medication error reports. The PIC timely and correctly processed all reports (MIT 7.112, 100%).

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

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

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

- Only three of 19 applicable patient samples received chronic care medications within required time frames (MIT 7.001, 15.8%). In 16 patients, we found one or more of the following deficiencies: chronic care medications were not made available to the patients in a timely manner; staff did not document the patient's stated reason for refusing medication; and KOP medications were not issued within policy time frames.
- The institution's pharmacy made available post-hospitalization medication orders within the required time frame for 11 of 16 applicable sampled patients (MIT 7.003.2, 68.8%). For five patients, the pharmacy did not fill and dispense medications as ordered in a timely manner.
- The institution administered or issued post-hospitalization medication orders within the required time frames for seven of 17 applicable sampled patients (MIT 7.003.3, 41.2%). In 10 patients, we found one or more of the following deficiencies: staff did not document the patient's stated reason for refusing medication or reason for not presenting to the

medication line; nursing staff failed to deliver medication to the patient by the ordering provider's administration date; staff did not issue KOP medications within policy time frames; documentation showed nursing staff delivered multiple supplies of the newly ordered medication within a shorter than normal replenishment time frame; and the record contained no evidence showing whether the patient refused or received medication.

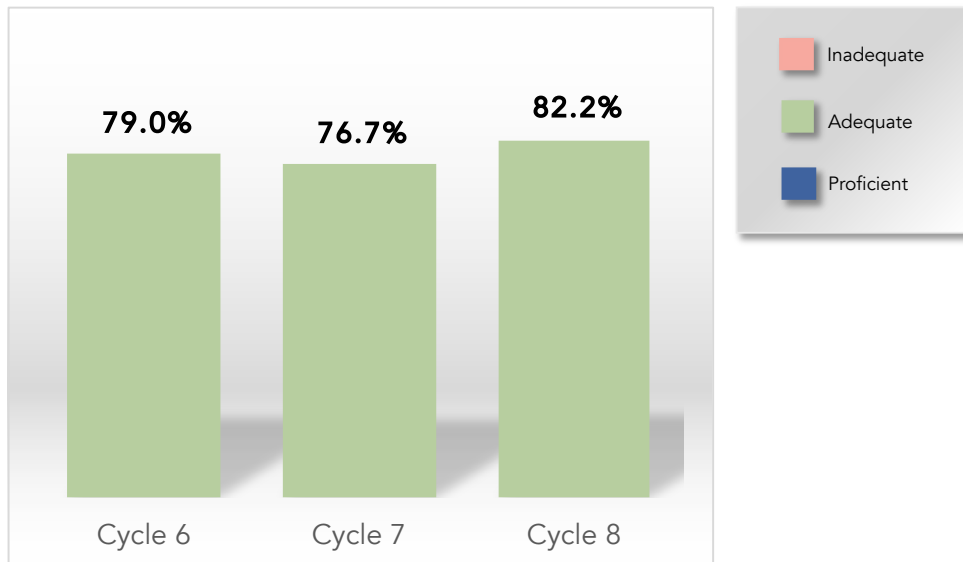
- The institution administered or delivered medications without interruption for patients transferring within the institution for 15 of 25 patients (MIT 7.005, 60.0%). For 10 patients, we found one or both of the following deficiencies: nursing staff failed to completely document the patient's stated reasons for refusing medication and reasons for not presenting to the medication line, or the record contained no evidence showing whether the patient refused or received the medication.
- The institution did not properly stored refrigerated or frozen medications in its main pharmacy (MIT 7.110, zero). The medication refrigerator was found unsanitary at the time of inspection.

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 SOL, 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. All 10 applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999, N/A).

Analysis of Performance Across Inspection Cycles

Figure 7. Medication Management, Compliance Scores Across Cycles



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

In Cycle 8, SOL performed well in **Medication Management**, achieving an *adequate* score of 82.2 percent. This rating follows a lower *adequate* score of 79.0 percent in Cycle 6 and a subsequently regressed *adequate* score of 76.7 percent in Cycle 7. The notable improvement this cycle indicates a successful commitment to progress, as the institution's scores are now trending closer to exceeding the minimum established standards for this indicator.

Table 18. Medication Management Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	3	16	6	15.8%
Did health care staff make available, new order prescription medications to the patient within the required time frames? (7.002.1)	21	1	3	95.5%
Did health care staff administer or issued new order prescription medications to the patient within the required time frames? (7.002.2)	25	0	0	100%
Upon the patient's discharge from a community hospital: Did the provider order the medications within required time frames? (7.003.1)	17	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)	11	5	1	68.8%
Upon the patient's discharge from a community hospital: Were all ordered medications administer or issued to the patient within required time frames? (7.003.3)	7	10	0	41.2%
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)	9	1	0	90.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	8	0	10	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)	8	1	9	88.9%
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)	9	0	9	100%
All clinical and medication line storage areas for non-narcotic medications: Does the institution safely store non-narcotic medications that have yet to expire in the assigned storage areas? (7.104)	9	0	9	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	5	1	12	83.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	5	0	13	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	6	0	12	100%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%

Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	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)	25	0	0	100%
For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This test is not scored. Please see the indicator for discussion of this test.			
For Information Purposes Only: Pharmacy: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This test is not scored. Please see the indicator for discussion of this test.			
Overall percentage (MIT 7): 82.2%				

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

Compliance Recommendations

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

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as being at high risk for coccidioidomycosis (valley fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Preventive Services: Compliance Ratings and Results Summary



SOL achieved outstanding compliance performance in this indicator. Based on the overall compliance score result of 93.7 percent, the OIG rated this indicator ***proficient***.

Compliance Testing Results

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

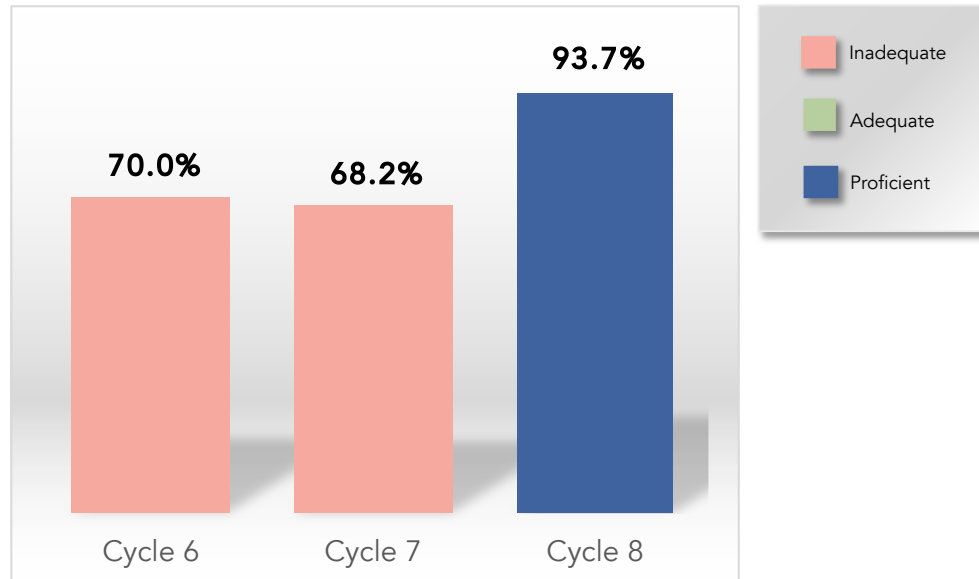
- The institution monitored patients taking TB medications during the treatment period for 14 of 15 applicable sampled patients (MIT 9.002, 93.3%). For one patient, the monthly monitoring was not completed within policy requirements.
- The institution demonstrated proficiency in screening patients for tuberculosis (TB) for all 25 patients (MIT 9.003, 100%).
- The institution demonstrated proficiency in offering influenza 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 all 25 patients (MIT 9.005, 100%).
- The institution offered immunizations to chronic care patients for 12 of 13 applicable sampled patients (MIT 9.008, 92.3%). For one chronic care patient, the record contained no evidence showing whether the patient received or refused their pneumococcal vaccinations.

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

- The institution properly administered TB medications for 13 of 17 sampled patients (MIT 9.001, 76.5%). For four patients, nursing staff did not document the patient's stated reason for refusing the medication or reason for not presenting the medication line.

Analysis of Performance Across Inspection Cycles

Figure 8. Preventative Services, Compliance Scores Across Cycles



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

In Cycle 8, SOL performed well 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 93.7 percent in Cycle 8. This score demonstrates a significant recovery following an *inadequate* performance result of 70.0 percent in Cycle 6 and a subsequent decline to a lower *inadequate* score of 68.2 percent in Cycle 7, indicating the institution has substantially progressed to now exceeding established benchmarks.

Table 19. Preventive Services Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	13	4	0	76.5%
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)	14	1	2	93.3%
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)	25	0	0	100%
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)	12	1	12	92.3%
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): 93.7%				

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

Compliance Recommendations

The OIG offers no compliance recommendations for this indicator.

Nursing Performance

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution’s nurses, including registered nurses (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. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing nursing performance, our clinicians understand that 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

SOL nurses generally delivered appropriate and timely nursing care throughout the institution, including outpatient settings, triage and treatment area (TTA), specialized medical housing (SMH), transfers process, hospital returns, and specialty services. However, our clinicians identified patterns in which nurses did not always perform complete assessments and did not always properly triage symptomatic sick call requests that required a same-day evaluation. 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	72	11

* We reviewed 165 nursing encounters in 59 cases. Of the nursing encounters we reviewed, 82 were in the outpatient setting.

† Deficiencies occurred in cases 1-3, 6-8, 15-21, 25, 30, 32-35, 38, 40, 43, 44, 46, 48, 50-52, 57, 59, 60-62, 64, 68, and 69.

‡ Significant deficiencies occurred in cases 7, 8, 16, 20, 33, 35, 38, 52, 57, and 69.

Table 21. Case Review Outpatient Nursing Performance Results

Outpatient Nursing Encounters*	Deficiencies†	Significant Deficiencies‡
82	35	5

* Nursing outpatient encounters occurred in cases 1-3, 6, 7, 15-19, 21, 35-66, 68, and 69. In the total number of nursing outpatient events, 57 were sick call events. Sick call events occurred in cases 1-3, 12, 15-18, 21, 35-66, and 68.

† Outpatient nursing deficiencies occurred in cases 1, 3, 6, 7, 15-19, 21, 35, 38, 40, 43, 44, 46, 48, 50-52, 57, 59-62, 64, and 68.

‡ Outpatient nursing significant deficiencies occurred in cases 16, 35, 38, 52, and 57.

Performed well

OIG clinicians found SOL performed well in the following areas:

- Transfer In

OIG clinicians found nurses screened patients appropriately for patients who transferred into the institution and scheduled provider follow-up appointments as required. Please refer to the **Transfers** indicator for further details.

- Transfer Out

OIG clinicians found nurses almost always ensured all requirements were met during the transfer out process. Please refer to the **Transfers** indicator for further details.

Performed Satisfactorily with Opportunities for Improvement

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

- Outpatient Nursing Assessment, Interventions, and Documentation

OIG clinicians found nurses generally provided appropriate nursing assessments and interventions, and they usually triaged sick call requests timely. However, we found opportunities for improvement with completing thorough nursing assessments and documentation. In a few cases, we identified the nurses triaged symptomatic sick calls

but did not assess the patient the same day for urgent symptoms or the next day for symptomatic complaints. The following are examples:

- In case 16, the patient with a history of chronic obstructive lung disease (COPD) submitted a sick call request complaining of congested lungs that were worsening every day and noting his inhaler was not helping with his symptoms.⁵⁹ The nurse did not arrange a same-day assessment for the urgent complaint. In addition, the nurse did not assess the patient for a recent fever and did not assess the patient's medication compliance including the frequency of his inhaler use.
- In case 35, the diabetic patient submitted a sick call request complaining of a small red lump under his left armpit, described as infected for two days with pain. The nurse did not initiate a same-day RN assessment but, instead, scheduled an appointment for the next day. Additionally, the nurse erroneously documented the wound was on the right side as well as on the left side.
- In case 38, the nurse triaged a sick call for a patient, who requested a physical and blood work, and who wrote he had a sharp burning pain in his right thigh for a couple months. The nurse incorrectly ordered an "asymptomatic" sick call appointment, so the patient was not seen until 10 days later, instead of the next business day. The nurse assessed this patient and addressed the patient's request for a physical and blood work; however, no documentation indicated the nurse assessed the patient's sharp burning pain in his thigh.
- In case 52, the nurse triaged a sick call request in which the patient complained of pain in his lower left stomach lasting for a few days. The nurse did not order a same-day appointment to assess the patient's abdominal pain complaint. Instead, the patient was seen three days later. In addition, during the clinic appointment, the nurse did not palpate the patient's abdomen and did not listen to the patient's bowel sounds. Furthermore, the nurse documented the patient had a left middle finger amputation a few days prior but did not assess the amputation site. The nurse also did not co-consult with the patient's primary care provider (PCP) or arrange a follow-up appointment.
- In case 57, the nurse assessed the patient, who had chronic kidney disease and complained of pain to his right side lasting for seven days. The RN did not co-consult with the PCP or initiate a prompt PCP appointment. Instead, the RN incorrectly ordered a 14-day PCP follow-up.

⁵⁹ Chronic obstructive pulmonary disease (COPD) is a chronic and progressive lung disease that damages the lungs and makes breathing more difficult by blocking or limiting airflow in and out.

- Care Coordination and Care Management

OIG clinicians reviewed one case in which a care coordinator or care manager provided care a patient. We identified one deficiency, which was not significant.⁶⁰

- Emergency Services

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

- Hospital Returns

OIG clinicians found nurses performed assessments upon the patients return from the 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 CTC nurses often conducted appropriate nursing assessments and interventions. Please refer to the **Specialized Medical Housing** indicator for further details.

- Wound Care

OIG clinicians reviewed one case in which SOL nurses provided wound care and identified three deficiencies, none of which were significant. Nurses intermittently performed incomplete wound assessments and incomplete documentation, and they intermittently did not complete wound care as ordered by the provider. The following is an example:

- In case 21, during the review period, nurses often performed dressing changes, but they did not always document wound assessments and wound care progress. In addition, on various occasions, nursing staff did not complete the wound care as ordered by the provider.

- Medication Management

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

⁶⁰ A care coordinator or care manager deficiency occurred in case 6, which was not significant.

- Specialty Services

Nurses generally performed appropriate assessments, interventions and documentation for patients returning from an offsite specialty appointment and/or consultation. Please refer to the **Specialty Services** indicator for further details.

Performed Poorly, Improvement Needed

OIG clinicians found no areas with which SOL performed poorly.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians interviewed nurses and medical staff in the TTA, SMH, receiving and release (R&R), specialty service clinics, outpatient clinics, medication administration areas, scheduling unit, and executive leadership.

In the outpatient areas, SOL had a total of eight care teams. Each team was made up of a provider, a primary care RN, and a medical assistant (MA) for provider support. All patients were escorted to the central health clinic (CHC) building for medical appointments and received their medications in their perspective yards. During our inspection, we attended four huddles. The huddles were well organized and run by the primary care RNs, who followed their huddle script. Clinic staff informed us of recent changes affecting care teams, which included a yard closure in March 2026 and the recent opening of the restricted housing unit (RHU) with enhanced outpatient program (EOP) level of care patients.⁶¹ The outpatient nurses indicated they saw an average of 10–12 patients per day and did not have any appointment backlog. The clinic nurses serve both the role as the primary care nurse and the care manager. The nurses often assess patients and provide education for those patients who are non-compliant with medications or treatments. Overall, nursing staff reported they felt supported in their roles and morale was positive.

During our interview with a clinic nursing supervisor, they shared they conducted monthly sick call audits for each RN in assigned care teams and performed random documentation audits for other nursing staff. The nursing supervisor also discussed a refusal work group currently in place,



Photo 13. Clinic Examination Room
Photo taken 7-29-2026

⁶¹ EOP is the enhanced outpatient program, a mental health program for patients.

which included medical and custody staff, to identify reasons for clinic appointments refusals and decrease the incidence of refusals.

During our on-site inspection, we met with the chief nurse executive (CNE) and the acting director of nursing (DON). Nursing leadership discussed current and completed quality improvement work groups, which included decreasing RN to PCP referrals, decreasing refusals of medical and clinic appointments, and increasing Suboxone compliance.⁶² Nursing leadership reported challenges related to not having a permanent DON and having various SRN II vacancies, but the leadership expressed an optimistic outlook due to the recent appointment of the acting DON.

Case Review Recommendations

- Nursing leadership should determine the root cause of challenges preventing nurses from performing appropriate triage of sick calls and completing thorough face-to-face assessments. Leadership should implement and monitor remedial measures as appropriate.

⁶² Suboxone is a medication containing buprenorphine and naloxone, which used to treat opioid dependence and addiction.

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 SOL provider performance improved overall since Cycle 7. SOL providers generally performed well in outpatient records review and provider continuity. They performed satisfactorily with opportunities for improvement in outpatient assessment and decision making, emergency care, chronic care, specialized medical housing, specialty services, and outpatient documentation quality. However, providers struggled with generating and sending complete patient test result notification letters. In this cycle, OIG clinicians reviewed 25 detailed cases and rated 23 *adequate* and two *inadequate*, as compared to 18 *adequate* and seven *inadequate* in Cycle 7. Moreover, while the total number of overall deficiencies and significant deficiencies increased in this cycle as compared to Cycle 7, most of these deficiencies were concentrated in two cases. Specifically, 26 of the 68 deficiencies (38 percent) in this cycle occurred in two cases, including one of the two *inadequate* cases. Hence, despite the increase of individual deficiencies, overall provider performance generally showed improvement. Although deficiencies remained in various areas, the reduction in *inadequate* cases and the satisfactory to good performance across multiple sub-indicators supported an overall rating of *adequate*.



Case Review Results

Table 22. Provider Performance Case Review Results

Provider Encounters*	Deficiencies†	Significant Deficiencies‡
112	68	27

* The OIG reviewed 112 provider encounters.

† Deficiencies occurred in cases 1, 2, 6, 8–11, 13–15, 18–24, 31, 33, 34, 67–69.

‡ Significant deficiencies occurred in cases 6, 8, 10, 13–15, 18–20, 24, 33, 67, and 69.

Table 23. Provider Performance Detailed Cases Results

Total Detailed Cases Reviewed	Proficient	Adequate	Inadequate
25	0	23	2

Performed Well

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

- Outpatient Records Review⁶³
- Provider Continuity⁶⁴

Performed Satisfactorily with opportunities for improvement

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

- Outpatient Assessment and Decision Making

Overall, providers usually performed satisfactorily in assessment or decision making. Within the 86 outpatient provider encounters, OIG clinicians identified 23 deficiencies, 12 of which were significant.⁶⁵ The deficiencies occurred across 12 cases, only two of which were *inadequate*.⁶⁶ Additionally, of the 10 providers attributed with these deficiencies, three providers were responsible for 65 percent of the deficiencies.⁶⁷ The following are examples of significant deficiencies:

- In case 6, the provider evaluated the patient for follow-up, documented a physical examination indicating clear lungs, and diagnosed stable COPD.⁶⁸ However, the provider also documented abnormal vital signs, including a high heart rate, elevated blood pressure, and critically low oxygenation. Although the patient had abnormal vital signs, the provider did not evaluate further and did not promptly intervene. Furthermore, the radiologist reported an abnormal chest x-ray and

⁶³ Deficiencies occurred in cases 2, 13, 15, 20, and 24. Significant deficiencies occurred in cases 13 and 15.

⁶⁴ OIG clinicians identified no deficiencies in this sub-indicator.

⁶⁵ Deficiencies in outpatient assessment and decision making occurred in cases 6, 9, 10, 14, 15, 19, 20, 23, 24, 67–69. Significant deficiencies occurred in cases 6, 10, 14, 15, 20, 24, and 67.

⁶⁶ Cases 6 and 20 were *inadequate*.

⁶⁷ One provider generated seven deficiencies and two other providers each generated four deficiencies. Six providers generated one deficiency each, and another provider generated two deficiencies.

⁶⁸ Chronic obstructive pulmonary disease (COPD) is a chronic and progressive lung disease that damages the lungs and makes breathing more difficult by blocking or limiting airflow in and out.

recommended a follow-up radiography. However, the provider ordered a repeat chest x-ray with routine-priority instead of a more urgent priority.

- In case 20, the provider evaluated the patient during a post-hospitalization follow-up for respiratory failure from heart failure and pneumonia. However, the provider did not perform a thorough cardiopulmonary examination, including listening to the heart and lungs as well as re-evaluating the patient's low heart rate.
- In case 24, the provider documented the cancer patient's eyes were "glazed," and the patient was slow to respond. However, the provider did not further evaluate or develop an assessment and plan.
- Emergency Care

SOL providers usually made accurate diagnoses, documented completely, and made sound triage and treatment decisions for TTA patients. OIG clinicians identified five provider performance deficiencies, three of which were significant as follows:⁶⁹

- In case 24, the TTA nurse consulted the provider about a rectal cancer patient, who complained of abdominal pain. The patient received a pain medication injection and an order for a nurse follow-up in three days. However, the provider did not document a progress note with medical reasoning for this care.
- In case 69, the nurse called the provider about a patient, who complained of eight out of 10 constant abdominal pain and anorexia for four days. The nurse identified a nodule in the mid-abdomen. The patient was also exposed to influenza and tested positive. The provider documented the patient's abdominal pain as a probable "viral AGE," which appears to refer to viral acute gastroenteritis," and ordered fluids as well as medication for nausea and pain. The patient's symptoms improved, and he returned to housing. The provider ordered the pain medication, Tylenol with codeine, to treat an undetermined cause of the patient's abdominal pain; however, Tylenol with codeine can mask worsening abdominal symptoms. The provider also did not order provider follow-up to further evaluate the mid-abdominal nodule.
- Also in case 69, the patient returned to SOL after a hospitalization for pneumonia and severe heart failure. The patient later presented to the TTA with shortness of breath and dizziness. The nurse documented notifying the provider. The patient received an electrocardiogram and returned to housing.⁷⁰ The provider did not

⁶⁹ Deficiencies occurred in cases 20, 24, and 69. Significant deficiencies occurred in cases 24 and 69.

⁷⁰ An electrocardiogram (EKG) is a non-invasive test measuring and recording the electrical impulses from the heart, used to help diagnose heart problems.

document a progress note detailing medical assessment, decision making, or plan of care.

We also discuss emergency care provider performance in the **Emergency Services** indicator.

- Chronic Care

Appropriate and timely management of patients' chronic medical conditions improves long term patient health and reduces emergency events. OIG clinicians reviewed 19 provider events involving chronic care and identified nine deficiencies related to care of chronic conditions.⁷¹ The following are examples of the significant deficiencies:

- In case 14, for the month of March, the patient received none of the diabetic medication, semaglutide. The reason listed in the MAR was "Refill Not Requested." The following month, the provider ordered a refill of the semaglutide and, again, did not order this prescription as automatic refill. This increased the risk of the patient not receiving this chronic care diabetic medication again.
- In case 18, the provider evaluated the patient during a chronic care appointment. The patient had a history of diabetic retinopathy and right eye blindness. However, the provider did not refer the patient to an eye specialist for further follow-up.
- In case 67, during the six-month review period, at three appointments, the provider evaluated the diabetic patient; however, the provider did not examine the patient's cardiovascular system.

- Specialized Medical Housing

SOL providers performed acceptably in the care of specialized medical housing patients. OIG clinician reviewers identified seven deficiencies, two of which were significant.⁷²

We discuss this further in the **Specialized Medical Housing** indicator.

- Specialty Services

OIG clinicians found SOL providers generally ordered appropriate specialty service referrals and followed up with specialists' recommendations timely. We reviewed 107

⁷¹ Deficiencies occurred in cases 9–11, 14, 18, 20, and 67. Significant deficiencies occurred in cases 10, 14, 18, and 67.

⁷² Deficiencies occurred in cases 8, 31, 33, and 34. Significant deficiencies occurred in cases 8 and 33.

specialty procedures and consultations and identified 17 deficiencies, six of which were significant.⁷³ The following are examples:

- In case 19, the provider reviewed urology specialist’s recommendations. The provider acknowledged the recommendation to “continue potassium citrate and hydrochlorothiazide for stone prevention.” However, the provider did not address the recommendation.
- In case 69, the provider reviewed the hospital and discharge records for the patient, who was newly diagnosed with heart failure, chronic kidney disease, and other conditions. The discharge documents included a recommendation for the patient to see a cardiologist for possible cardiac MRI in one month. However, the provider did not order the cardiology referral or cardiac MRI test.

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

- Outpatient Documentation Quality

OIG clinicians reviewed 86 provider encounters and identified seven deficiencies, none of which were significant.⁷⁴ Four related to inaccurate or incomplete documentation, and three related to missing documentation.

Performed Poorly, Improvement Needed

OIG clinicians found SOL performed poorly and needed improvement in the following area:

- Patient Notification Letters

Providers needed improvement in consistently relaying complete and timely diagnostic test result notification letters to their patients. Providers often sent late patient notification letters, sent incomplete patient test result notification letters, or did not send the letters at all. OIG clinicians identified 26 deficiencies, none of which were significant.⁷⁵

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

⁷³ Deficiencies occurred in cases 1, 15, 19, 20, 24, 33, and 69. Significant deficiencies occurred in cases 19, 20, 24, and 69.

⁷⁴ Deficiencies in outpatient documentation occurred in cases 9, 11, and 21–23. No significant deficiencies occurred.

⁷⁵ Deficiencies occurred in cases 8, 11, 17–20, 22–24, 32, 33, and 67. No significant deficiencies occurred.

Clinician On-Site Inspection

The OIG clinicians attended morning huddles, which were well attended by providers, nurses, medical assistants, and custody. Custody briefly attended the beginning of the huddles to report on any custody-related issues. The patient care teams generally knew their patients well and clearly communicated their needs to one another. Most medical assistants and nurses reported good working relationships with their providers, and the providers generally felt supported by their assigned medical assistants and nurses.

The chief medical executive (CME) and chief physician and surgeon (CP&S), who had both worked at SOL for more than 10 years, reported recently having fully staffed all provider positions with the May 2026 budget, which helped to eliminate their prior provider appointment backlog. Medical leadership reported a surge of appointment backlogs in February and March 2026 due to provider shortage.

Providers were forthcoming about medical leadership and practices. The providers reported the CP&S readily evaluated patients when some providers' schedules became too busy. Telemedicine providers also expressed appreciation for their ability to discuss with the CP&S about performing physical evaluations on their patients as needed. When asked about challenges they face, providers mentioned concern with patients failing to timely arrive at their scheduled appointment times. In addition, most providers reported inconsistent access to some specialty services. All providers reported felt well supported by both the CME and CP&S, and their morale was generally good.



Photo 14. Provider clinic examination room.
Photographed on 7-29-2026.

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, SOL’s specialized medical housing consisted of a correctional treatment center (CTC).

Specialized Medical Housing: Case Review Ratings and Results Summary

SOL generally provided acceptable medical care for specialized medical housing patients. Providers usually delivered good care and performed timely admission assessments. CTC nurses often performed good assessments, conducted rounds as required, and maintained medication continuity for newly admitted patients to the CTC. However, the OIG clinicians identified patterns of questionable provider decision-making. Considering all factors, the OIG rated the case review component of this indicator *adequate*.



Case Review Results

Table 24. Specialized Medical Housing Case Review Results

CTC Events*	Deficiencies†	Significant Deficiencies‡
77	26	6

* We reviewed five cases that included 23 provider encounters and 26 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 8, and 31-34.

‡ Significant deficiencies occurred in cases 8 and 33.

Performed Well

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

Performed Satisfactorily with Opportunities for Improvement

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

- Medication Management⁷⁶

OIG clinicians found SOL generally provided medications timely. Please refer to the **Medication Management** indicator for further details.

- Nursing Performance⁷⁷

OIG clinicians found CTC nurses often conducted appropriate nursing assessments and interventions. In one case, our clinicians identified multiple deficiencies when nurses did not perform appropriate assessments and interventions pre- and post-gastrostomy tube (G-tube) feeding.⁷⁸ The significant deficiency is below:

- In case 33, the patient was admitted to CTC for continuous G-tube feedings. Nursing staff did not always document whether the G-tube was flushed before and after medications and did not always check residual balances after feeding.

- Provider Performance⁷⁹

Providers generally delivered good care, and provider follow-up intervals were usually timely. OIG clinicians identified only one minor instance of a delayed provider endorsement of hospital records and one minor instance of ordering specialty follow-up at a longer-than-recommended interval. However, while the providers timely completed the admission history and physical examinations, we identified a pattern of four decision-making lapses, with the following significant examples:

- In case 8, the provider documented a low patient oxygen saturation on the admission history and physical examination notes but did not perform a cardiopulmonary examination or review the patient's previous oxygenation readings to confirm the patient's baseline oxygenation level.
- In case 33, the provider admitted the patient to the CTC for severe weight loss. However, the provider did not order regular weekly weight checks for close monitoring.

⁷⁶ Deficiencies occurred in cases 32–34. Three significant deficiencies occurred in case 33.

⁷⁷ Deficiencies occurred in cases 8 and 32–34. A significant deficiency occurred in case 33.

⁷⁸ A gastrotomy tube (G-tube) is a tube inserted through the abdomen that brings nutrition directly to the stomach.

⁷⁹ Deficiencies occurred in cases 8, 31, 33, and 34. Significant deficiencies occurred in cases 8 and 33.

Performed Poorly, Improvement Needed

OIG clinicians found no areas with which SOL performed poorly.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians inspected the CTC. The CTC had six medical beds and nine mental health crisis beds, including one room that included three beds with trapeze bars for patients who required assistance.⁸⁰ At the time of the onsite inspection, six medical beds were occupied. CTC staff held huddles daily, which included all required members. The nurses stated the CTC was staffed with a mixed ratio of RNs, LVNs, certified nursing assistants, and psychiatric technicians. The CTC had a designated provider during business hours. After hours, the nurses contacted the on-call provider for any problems or orders. CTC Staff reported feeling supported by executive staff and having a good working relationship with custody.



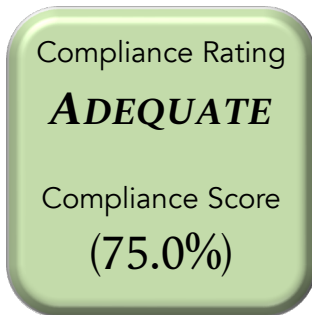
Photo 15. CTC Examination and Supply Room.
Photo taken 7-29-2026.

Case Review Recommendations

The OIG offers no case review recommendations for this indicator.

⁸⁰ A trapeze bar is a horizontal bar suspended by ropes or chains and used as a tool for patients to grab to sit up, shift weight, or move around without heavy lifting from medical staff.

Specialized Medical Housing: Compliance Ratings and Results Summary



SOL presents opportunities for improvement in this indicator. Based on the overall compliance score result of 75.0 percent, the OIG rated the compliance component of this indicator ***adequate***.

Compliance Testing Results

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

- Providers performed excellently in completing written history and physical examinations within the required time frame for both of the two applicable sampled patients (MIT 13.002, 100%).
- Providers exhibited proficiency in ordering medications within the required time frames upon the patients' admissions for both of the two applicable sampled patients (MIT 13.003.1, 100%).
- The institution maintained an operational call light system during the on-site inspection (MIT 13.101, 100%).

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

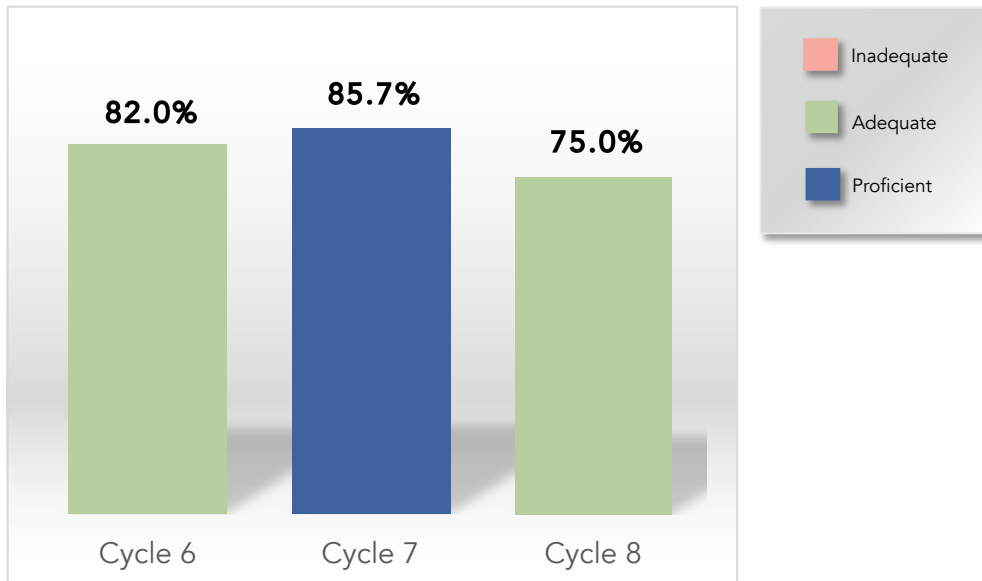
- Registered nurses (RNs) completed an initial assessment of the patient at the time of admission for only one of the two applicable sampled patients (MIT 13.001, 50.0%). For one patient, the RN did not complete the initial assessment timely.
- Health care staff ensured all ordered medications were made available for only one of the two applicable sampled patients within the required time frames (MIT 13.003.2, 50.0%). For one patient, the pharmacy was not timely in filling and dispensing medications as ordered.
- Health care staff ensured all ordered medications were administered to the patient for only one of the two applicable sampled patients within the required time frames (MIT 13.003.3, 50.0%). For one patient, nursing staff did not administer nurse-administered (NA) medications within the provider's ordered timelines.

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

- SOL 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).

Analysis of Performance Across Inspection Cycles

Figure 9. Specialized Medical Housing, Compliance Scores Across Cycles



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

In Cycle 8, SOL met established standards for this indicator, successfully reaching the 75.0 percent passing compliance threshold with an *adequate* score of 75 percent. However, this score represents a decline from a previously higher *adequate* rating of 82.0 percent in Cycle 6 followed by a *proficient* rating of 85.7 percent in Cycle 7. This recent regression indicates that, while the institution continues to meet minimum benchmarks, performance has decreased over the last cycle to the minimum necessary to pass this indicator.

Table 25. Specialized Medical Housing Compliance Test Scores

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001)	1	1	0	50.0%
Was a written history and physical examination completed within the required time frame? (13.002)	2	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)	2	0	0	100%
Upon the patient's admission to specialized medical housing: Were all ordered medications made available within required time frames? (13.003.2)	1	1	0	50.0%
Upon the patient's admission to specialized medical housing: Were all ordered medications administer or issued to the patient within required time frames? (13.003.3)	1	1	0	50.0%
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): 75.0%				

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

Compliance Recommendations

- Nursing leadership should develop strategies to ensure nurses timely complete initial CTC assessments as required by CCHCS policy. Leadership should implement and monitor remedial measures as appropriate.

Specialty Services

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

Specialty Services: Case Review Ratings and Results Summary

In this cycle, case review found SOL performed satisfactorily in delivering specialty services for its patients, improving since Cycle 7. SOL staff frequently obtained and scanned specialty services reports timely, better than in Cycle 7. Nurses mostly completed appropriate assessments and documentation for patients returning from specialty appointments. Providers often referred patients to the appropriate specialists and followed specialists’ recommendations. Although specialty service appointments occurred on or before ordered timeframes, we identified examples of providers ordering specialty referrals for medically inappropriate timeframes. After considering all factors, the OIG rated the case review component of this indicator ***adequate***.



Case Review Results

Table 26. Case Review Specialty Services Results

Specialty Services Related Events*	Deficiencies†	Significant Deficiencies‡
117	40	12

* The OIG reviewed 117 events, which include 107 specialty consultations and procedures, and 10 nursing encounters.

† Deficiencies occurred in cases 9, 15, 19-20, 22-24, 31, 33, and 69.

‡ Significant deficiencies occurred in cases 15, 19-20, 22-24, and 3.

Performed Well

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

Performed Satisfactorily with Opportunities for Improvement:

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

- Access to Specialty Services

Of the 107 specialty services consultations and procedures, most occurred as ordered; however, OIG clinicians identified five deficiencies, four of which were significant.⁸¹ The deficiencies included inappropriate scheduling as well as late or missed appointments. The following are examples of significant deficiencies:

- In case 20, the provider ordered a follow-up appointment with the cardiologist for heart failure and abnormal heart rhythms as well as an appointment for a pacemaker check. However, the patient only had a pacemaker check and did not receive the appointment with the cardiologist.
- In case 22, the patient underwent a PET scan for lung cancer evaluation ten days late.⁸²
- In case 24, the patient undergoing cancer treatment missed three appointments because of inappropriate scheduling. The patient missed two important telemedicine cancer specialist appointments, because he was scheduled with off-site specialty appointments on the same dates. In addition, the patient similarly missed a primary care appointment, because he went to an appointment with an off-site specialist that was also scheduled the same day.

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

- Provider Performance

OIG clinicians identified 17 provider performance deficiencies, six of which were significant. Providers usually ordered clinically indicated specialty referrals; however, OIG clinicians identified a pattern of ten deficiencies in four cases where providers ordered, and leadership approved, specialty referrals with medically inappropriate compliance timeframes. Deficiency severity was mitigated because the specialty appointments usually occurred earlier than ordered and within compliance timeframes.⁸³

⁸¹ Deficiencies occurred in cases 15, 21, 22, 24, and 69. Significant deficiencies occurred in cases 20, 22, and 24.

⁸² A positron emission tomography (PET) scan is an imaging test of organs and soft tissues.

⁸³ Deficiencies occurred in cases 1, 15, 19, 20, 24, 33, and 69. Significant deficiencies occurred in cases 19, 20, 24, 33, and 69. Deficiencies related to ordering and approving specialty service referral with medically inappropriate timeframes occurred in cases 1, 20, 24, and 33. Significant deficiencies occurred in cases 20, 24, and 33.

In addition, providers generally followed specialty recommendations; however, in three cases, they did not.⁸⁴ The following are examples of significant deficiencies:

- In case 20, the provider reviewed hospital discharge recommendations for a cardiology specialty follow-up appointment within 1 to 2 weeks. However, the provider ordered the cardiology referral as routine priority to occur in 45-90 days, delaying care to the patient.
- In case 24, the provider ordered an important procedure for a colon mass removal for a patient diagnosed with rectal cancer as medium priority (to occur within 14 or up to 45 days) and specified a “due by” date of nearly one and one half months later. The provider also ordered important medical imaging needed to further evaluate the patient’s cancer medium priority and with a “due by” date of one and one half months later. The colorectal surgeons recommended the MRI be completed urgently; thus, both referrals should have been ordered to occur urgently (within 14 days).
- Also in case 24, the nurse communicated to the provider that the cancer specialist recommended laboratory tests before the next appointment, so the cancer specialist could present the patient’s test results to a specialty cancer team. However, the provider did not order the tests timely, which delayed the cancer specialist’s ability to receive the test results.

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

- Nursing Performance

Nurses generally performed appropriate assessments, interventions, and documentation for patients returning from an off-site specialty services appointment. However, OIG clinicians identified five deficiencies in ten events reviewed, which included incomplete nursing assessments and documentation as well as a few occasions in which nurses did not obtain recommendations from the off-site specialist.⁸⁵ The following is an example:

- In case 21, the patient returned from an offsite follow-up orthopedic appointment on three occasions. On each occasion, the nurse assessed the patient; however, the nurse did not contact the offsite specialist for recommendations.

⁸⁴ Three deficiencies occurred in cases 15, 19, and 24.

⁸⁵ Nursing performance events occurred in cases 1, 3, 19-21, 32, and 33. Nursing deficiencies occurred in cases 19, 21, and 33. No significant deficiencies occurred.

- Health Information Management (HIM)

HIM staff often retrieved, scanned, and filed specialty consultations appropriately; however, we identified 13 deficiencies, two of which were significant.⁸⁶ OIG clinicians identified a pattern of late scanning and endorsement of specialty service reports. The following are examples of significant deficiencies:

- In case 15, the hearing specialist completed a hearing assessment for the patient; however, staff scanned the report into EHRS over two weeks late.
- In case 23, the dermatologist evaluated the patient to follow up on a skin condition and important medication adjustment. SOL staff retrieved the report late, and then additionally, the provider endorsed it a week late.

Performed Poorly, Improvement Needed

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

Clinician On-Site Inspection

OIG clinicians met with medical leadership, providers, and specialty nurses to discuss specialty services at SOL. SOL specialty nurses described difficulty in obtaining appointments for the following specialty services: ENT, orthopedics, rheumatology, and urology.⁸⁷ The SOL telemedicine specialty nurse reported utilizing EHRS to track completion of specialty appointments. The nurses also held weekly Thursday meetings to discuss specialty access-related concerns.

During the on-site inspection, SOL specialty leadership relayed, per CCHCS, all specialty referrals can only be ordered as routine-priority or high-priority, while medium-priority was discontinued. Specialty nurses and providers reported the process of ordering routine-priority for most referrals and attaching notes requesting more urgent timeframes to try to obtain



Photo 16. Entrance to the Specialty examination room. Photographed on 7-29-2026.

⁸⁶ Deficiencies occurred in cases 8, 9, 15, 22-25, 31, 33, and 69. Significant deficiencies occurred in cases 15 and 23.

⁸⁷ An ENT specialist diagnoses and manages ear, nose, and throat medical conditions.

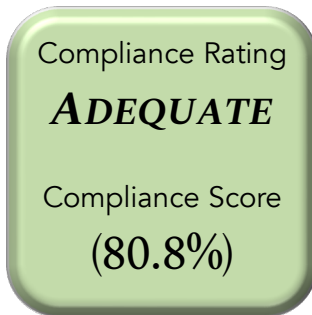
appointments sooner for patients. Providers reported adhering to this process was challenging. Some providers reported difficulty with obtaining approvals for RFS, despite meeting InterQual criteria, and a majority of providers expressed the need for more specialty service availability to ensure more timely completion of appointments.⁸⁸

Case Review Recommendations

- Health care leadership should develop measures to ensure SOL timely retrieve specialty reports, and providers timely review these reports. Leadership should implement and monitor remedial measures as appropriate.
- Health care leadership should develop measures to ensure specialty service referral medically appropriate timeframes match ordered timeframes. Leadership should implement and monitor remedial measures as appropriate.

⁸⁸ The request for service (RFS) is a referral order for a specialty service appointment. InterQual is an evidenced-based clinical support tool used to assist in determining whether proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required.

Specialty Services: Compliance Ratings and Results Summary



SOL exhibited good performance in this indicator. Based on the overall compliance score result of 80.8 percent, the OIG rated the compliance component of this indicator *adequate*.

Compliance Testing Results

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

- The institution received high-priority specialty service consultant reports within the required time frames for both of the two applicable sampled patients (MIT 14.002.1, 100%).
- The institution achieved proficiency in ensuring providers reviewed the high-priority specialty service consultant reports within the required time frames in both of the two applicable sampled patients (MIT 14.002.2, 100%).
- The institution provided subsequent follow-up appointments after a high-priority specialty service for the one applicable sampled patient (MIT 14.003, 100%).
- The institution achieved proficient performance in ensuring providers reviewed the medium-priority specialty service consultant reports within the required time frames for 13 of 14 applicable sampled patients (MIT 14.005.2, 92.9%). For one patient, the provider reviewed the report seven days late.
- The institution provided subsequent follow-up appointments after a medium-priority specialty service for six of seven applicable sampled patients (MIT 14.006, 85.7%). For one patient, the subsequent follow-up appointment occurred four days late.
- The institution ensured patients timely received their routine-priority specialty services within 90 calendar days for 14 of 15 sampled patients (MIT 14.007, 93.3%). For one patient, the record contained no evidence of a signed refusal form for the refused specialty service during our review period.
- The institution ensured providers reviewed the routine-priority specialty service consultant reports within the required time frames for 13 of 14 applicable sampled patients (MIT 14.008.2, 92.9%). For one patient, the record contained no evidence the provider reviewed the specialty service consultant report during our review period.

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

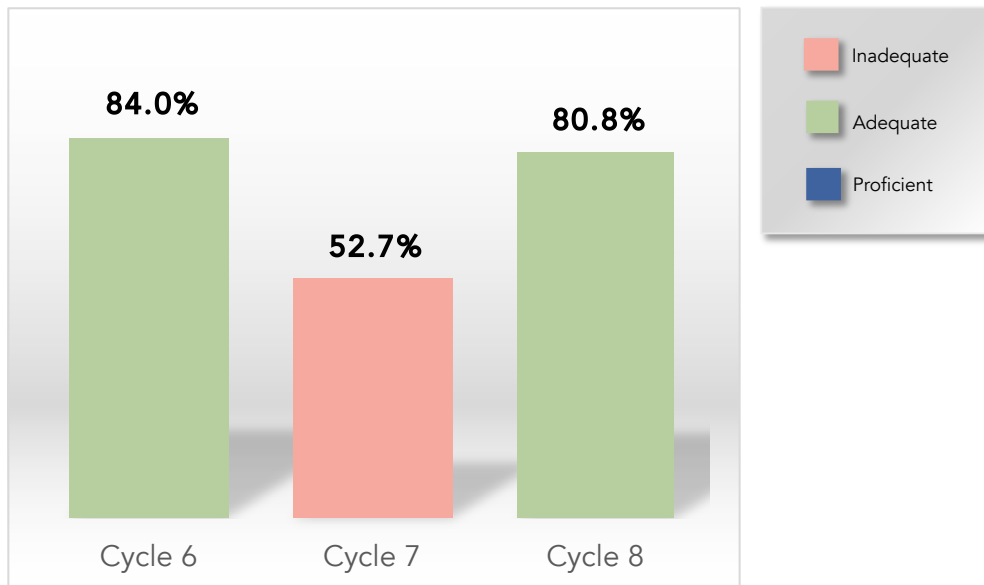
- The institution received routine-priority specialty service consultant reports within the required time frames for 10 of 13 applicable sampled patients (MIT 14.008.1, 76.9%). For three patients, the reports were received between one and four days late.
- The institution performed satisfactorily in providing subsequent follow-up appointments after a routine-priority specialty service for four of five applicable sampled patients (MIT 14.009, 80.0%). For one patient, the provider failed to document whether they agreed or disagreed with the specialist recommendation, as required by policy.
- The institution demonstrated sufficient performance in timely denying the Request for Services (RFS) as required by CCHCS policy for 15 of 20 sampled patients (MIT 14.011, 75.0%). For five patients, the RFSs were denied between one and three days late.

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

- The institution demonstrated proficiency in ensuring patients received high-priority specialty services within 14 calendar days for two of three applicable patients (MIT 14.001, 66.7%). For one patient, the record contained no evidence the high-priority specialty appointment was completed as ordered during our review period.
- The institution ensured patients received medium-priority specialty services within 15 to 45 calendar days for 10 of 15 sampled patients (MIT 14.004, 66.7%). For five patients, the service was provided between two and 54 days late.
- The institution received medium-priority specialty service consultant reports within the required time frames for eight of 12 applicable sampled patients (MIT 14.005.1, 66.7%). For four patients, the reports were received between one and five 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 eight patients, we found the following deficiencies: the services were provided between four and 95 days late or the record contained no evidence the specialty service appointment occurred during our review period.
- Providers informed 11 of 20 sampled patients of the denied RFS within the required time frame (MIT 14.012, 55.0%). For nine patients, we found the following deficiencies: the record contained no evidence the provider discussed the denied specialty service request with the patient; the provider informed the patient of the denied service between two and 24 days late; or the record contained no evidence of a signed refusal form for the refused appointment during our review period.

Analysis of Performance Across Inspection Cycles

Figure 10. Specialty Services, Compliance Scores Across Cycles



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

In Cycle 8, SOL met established standards for this indicator, achieving an *adequate* score of 80.8 percent. This rating demonstrates a substantial recovery to established benchmarks after a previous *adequate* score of 84.0 percent in Cycle 6, followed by a significant subsequent regression to an *inadequate* performance of 52.7 percent in Cycle 7. The institution's return toward its high *adequate* Cycle 6 performance signifies the institution's commitment to implementing successful improvements in this indicator.

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)	2	1	0	66.7%
Did the institution receive the high-priority specialty service consultant report within the required time frame? (14.002.1)	2	0	1	100%
Did the institution review the high-priority specialty service consultant report within the required time frame? (14.002.2)	2	0	1	100%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider or did the provider document their disagreement with the specialist's recommendation(s)? (14.003)	1	0	2	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)	10	5	0	66.7%
Did the institution receive the medium-priority specialty service consultant report within the required time frame? (14.005.1)	8	4	3	66.7%
Did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005.2)	13	1	1	92.9%
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)	6	1	8	85.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	14	1	0	93.3%
Did the institution receive the routine-priority specialty service consultant report within the required time frame? (14.008.1)	10	3	2	76.9%
Did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008.2)	13	1	1	92.9%
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)	4	1	10	80.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	12	8	0	60.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	15	5	0	75.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	11	9	0	55.0%
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.

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



SOL demonstrated perfect performance in this indicator. Based on the overall compliance score result of 100 percent, the OIG rated this indicator **proficient**.

Compliance Testing Results

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

- The institution's Quality Management Committee (QMC) consistently met monthly during our review period (MIT 15.002, 100%).
- The institution's Local Governing Body (LGB) met quarterly and discussed local operation procedures and any applicable policies during our review period (MIT 15.003, 100%).
- The institution responded to the medical grievances as well as timely and properly addressed all 10 patient appeals during our review period (MIT 15.101, 100%).

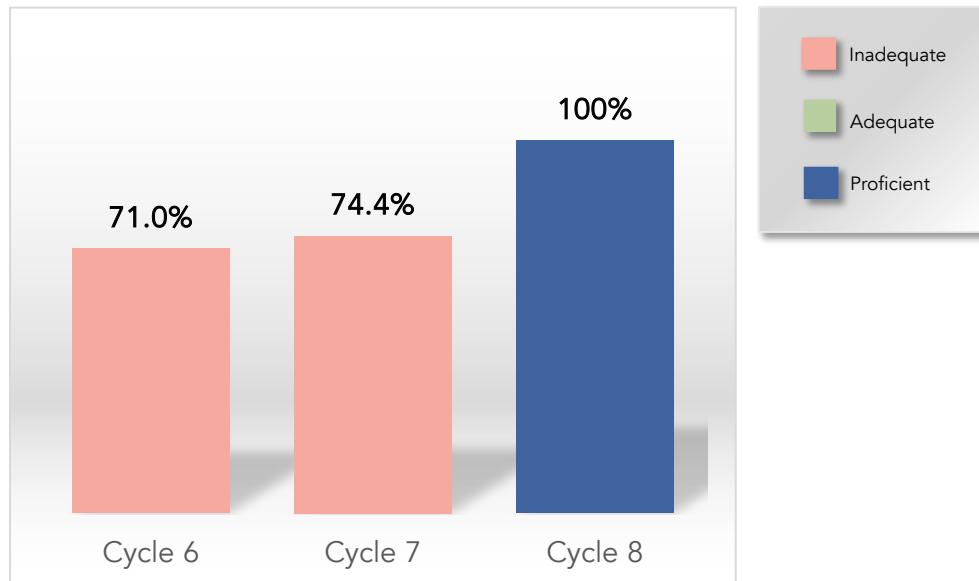
- The institution timely reviewed and completed the initial patient death reports for all five sampled patient deaths (MIT 15.102, 100%).
- Supervising registered nurses ensured the clinical competency of all nurses administering medications were timely completed during our review period (MIT 15.103, 100%).
- The medical leadership completed clinicians' performance appraisals timely for all five sampled clinicians (MIT 15.104, 100%).
- All 15 providers maintained valid state medical licenses (MIT 15.105, 100%).
- Nurses and the pharmacist-in-charge (PIC) maintained valid professional licenses and certifications. In addition, the institution's pharmacy had current pharmacy licenses (MIT 15.106, 100%).
- The pharmacy and providers maintained valid DEA registration. In addition, the pharmacy maintained valid Automated Drug Delivery System (ADDS) licenses (MIT 15.107, 100%).
- We obtained CCHCS Mortality Case Review reporting data. The institution's CEO and their designees completed the multidisciplinary review of the significant events leading to all five patient deaths during our review period (MIT 15.998 [scored component], 100%).

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

- At SOL, the institution had one reported adverse sentinel event requiring root cause analysis during our inspection period. For one report, SOL did not report the sentinel event timely as required by CCHCS policy (MIT 15.001, N/A).
- The compliance test for MIT 15.108 in this indicator was deemed not applicable as the institution did not hire nursing staff during the review period.
- 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 five 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 SOL Cycle 6 and Cycle 7 Medical Inspection Reports available here: www.oig.ca.gov.

In Cycle 8, SOL exceeded established standards, reaching a *proficient* score of 100 percent. This score surpasses the 75.0 percent passing compliance threshold and demonstrates a remarkable improvement from consecutive *inadequate* scores of 71.0 percent in Cycle 6 and 74.4 percent in Cycle 7, indicating a highly successful upward trajectory to exceeding established benchmarks.

Table 28. Administrative Operations Compliance Test Scores

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

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

Compliance Recommendations

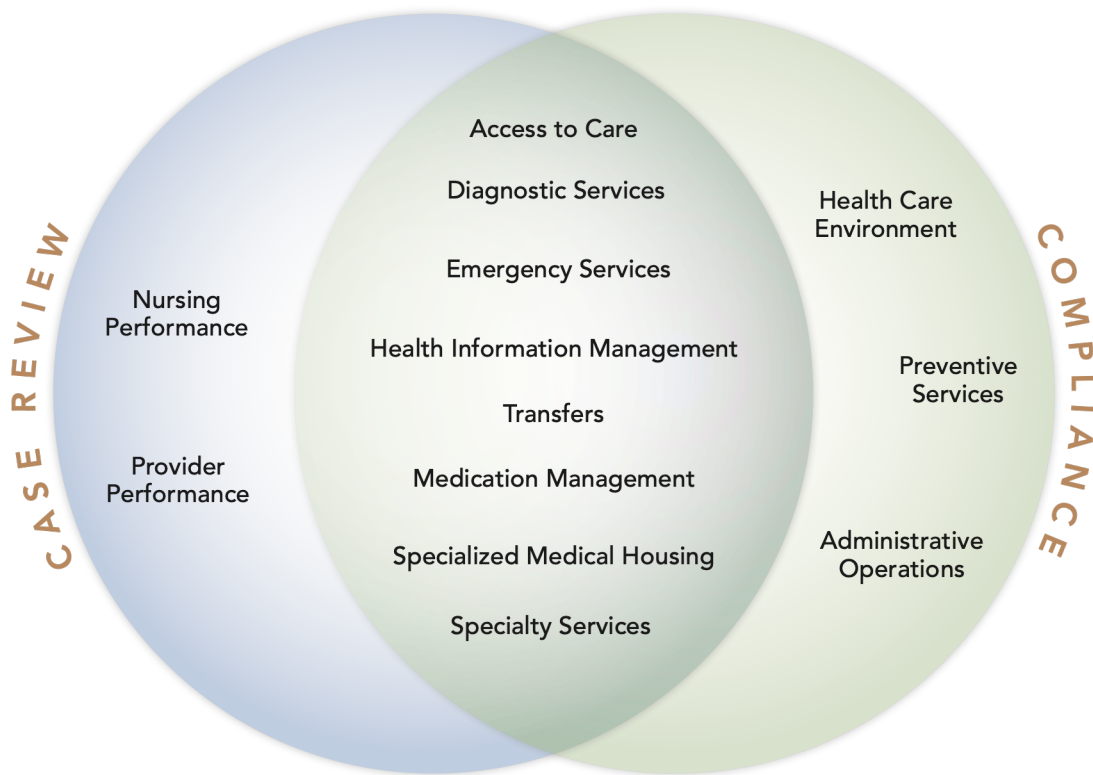
The OIG offers no compliance recommendations for this indicator.

Appendix A: Methodology⁸⁹

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 SOL



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 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

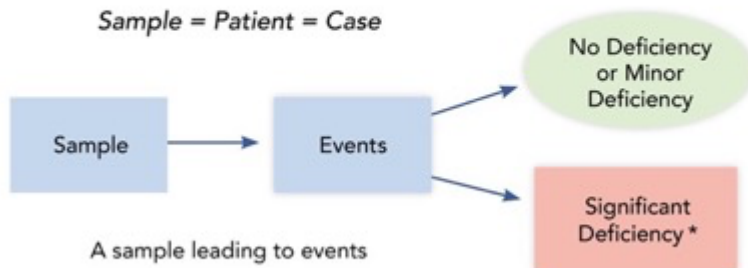
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review **events**. Our clinicians also record medical errors, which we refer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

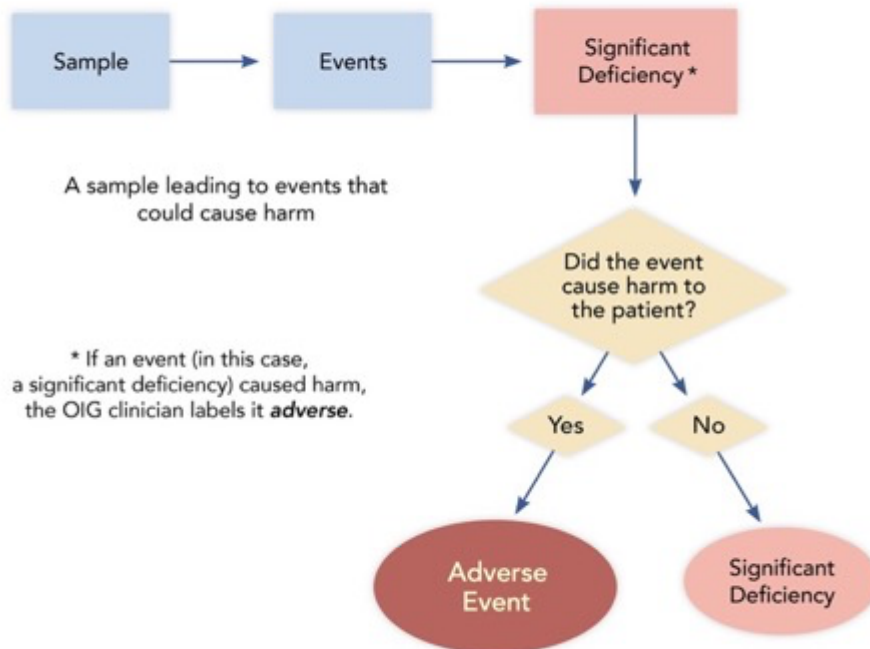
Figure 13. Case Review Testing

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. SOL Case Review Sample Sets.

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	4
Emergency Services – CPR	2
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	32
Specialty Services	3
	69

Table 31. SOL Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	4
Anticoagulation	2
Arthritis/Degenerative Joint Disease	13
Asthma	12
Cancer	6
Cardiovascular Disease	7
Chronic Kidney Disease	9
Chronic Pain	14
Cirrhosis/End-State Liver Disease	3
COPD	6
COVID-19	3
Diabetes	12
Gastroesophageal Reflux Disease (GERD)	11
Hepatitis C	13
HIV	1
Hyperlipidemia	35
Hypertension	29
Mental Health	15
Seizure Disorder	2
Sleep Apnea	1
Substance Abuse	19
Thyroid Disease	3
	220

Table 32. SOL Case Review Events by Program

Diagnosis	Total
Diagnostic Services	121
Emergency Care	41
Hospitalization	22
Intra-System Transfers In	13
Intra-System Transfers Out	8
Outpatient Care	386
Specialized Medical Housing	77
Specialty Services	139
	807

Table 33. SOL Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	25
MD Reviews Focused	4
RN Reviews Detailed	15
RN Reviews Focused	43
Total Reviews	87
Total Unique Cases	69
Overlapping Reviews (MD & RN)	18

Appendix C: Compliance Sampling Methodology

California State Prison, Solano

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Access to Care</i>				
MIT 1.001	Chronic Care Patients	25	Master Registry	Chronic care conditions (at least one condition per patient—any risk level) Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	40	Clinic Appointment List	Clinic (each clinic tested) Appointment date (1–7 months) Randomize
MIT 1.007	Returns From Community Hospital	17	OIG Q: 4.005	See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	33	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
<i>Diagnostic Services</i>				
MITs 2.001–003	Radiology	10	Radiology Logs	Appointment date (30 days–7 months) Randomize
MITs 2.004–006	Laboratory	10	Quest	Appt. date (30 days–7 months) Order name (CBC, BMP, or CMPs only) Randomize Abnormal

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 2.007-009	Laboratory STAT	6	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
<i>Emergency Services</i>				
MIT 3.001	EMRRC	12	EMRRC meeting minutes	Monthly meeting minutes (6 months)
MITs 3.101 - 103	Clinical Sub-indicators	16	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	3	On-site certification tracking logs	All staff Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)
<i>Health Information Management (Medical Records)</i>				
MIT 4.001	Health Care Services Request Forms	40	OIG Qs: 1.004	Non-dictated documents First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	33	OIG Qs: 14.002, 14.005 & 14.008	Specialty documents First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	17	OIG Q: 4.005	Community hospital discharge documents First 20 IPs selected

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
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	17	CADDIS off-site admissions	Date (1-7 months) Most recent 6 months provided (within date range) Rx count Discharge date Randomize
<i>Health Care Environment</i>				
MITs 5.101-105 MITs 5.107-111	Clinical Sub-indicators	16	OIG inspector on-site review	Identify and inspect all on-site clinical areas
<i>Transfers</i>				
MITs 6.001-003	Intra-system Transfers	25	SOMS	Arrival date (1-7 months) Arrived from (another departmental facility) Rx count Randomize
MIT 6.101	Transfers Out	3	OIG inspector on-site review	R&R IP transfers with medication
<i>Pharmacy and Medication Management</i>				
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	17	OIG Q: 4.005	See Health Information Management (Medical Records) (returns from community hospital)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	Date of transfer (1–7 months) To location/from location (yard to yard and to/from ASU) Remove any to/from MHCB NA/DOT meds (and risk level) Randomize
MIT 7.006	En Route	10	SOMS	Date of transfer (1–7 months) Sending institution (another departmental facility) Randomize NA/DOT meds
MITs 7.101–103	Medication Storage Sub-indicators	18	OIG inspector on-site review	Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Sub-indicators	18	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	25	Medication error reports	All medication error reports Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	10	On-site active medication listing	KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units
<i>Prenatal and Postpartum Care</i>				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	Delivery date (2–12 months) Most recent deliveries (within date range)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 8.001-007	Pregnant Arrivals	N/A at this institution	OB Roster	Arrival date (2-12 months) Earliest arrivals (within date range)
<i>Preventive Services</i>				
MITs 9.001-002	TB Medications	17	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)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
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
<i>Reception Center</i>				
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
<i>Specialized Medical Housing</i>				
MITs 13.001-003	Specialized Health Care Housing Unit	2	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
<i>Specialty Services</i>				
MITs 14.001-003	High-Priority Initial and Follow-Up RFS	3	Specialty Services Appointments	Approval date (3-9 months) Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender services Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MITs 14.004-006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	Approval date (3-9 months) Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services Randomize
MITs 14.007-009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	Approval date (3-9 months) Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services Randomize
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	Arrived from (other departmental institution) Date of transfer (3-9 months) Randomize
MITs 14.011-012	Denials	20	InterQual	Review date (3-9 months) Randomize
MITs 14.011-012	Denials	N/A	IUMC/MAR Meeting Minutes	Meeting date (9 months) Denial upheld Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Administrative Operations</i>				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	Adverse/Sentinel events (12months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	Meeting minutes (12 months)
MIT 15.003	LGB	4	LGB meeting minutes	Quarterly meeting minutes (12 months)
MIT 15.101	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	Medical grievances closed (6 months)
MIT 15.102	Death Reports	5	Institution-list of deaths in prior 12 months	Most recent 10 deaths Initial death reports
MIT 15.103	Nursing Staff Validations	10	On-site nursing education files	On duty one or more years Nurse administers medications Randomize
MIT 15.104	Provider Annual Evaluation Packets	5	On-site provider evaluation files	All required performance evaluation documents
MIT 15.105	Provider Licenses	15	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
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	5	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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October 26, 2026

Amarik Singh, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

California Correctional Health Care Services has reviewed the case review and compliance draft indicators for the Office of the Inspector General's Cycle 8 medical inspection of California State Prison, Solano. Thank you for preparing the report.

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

Sincerely,

Signed by:

DeAnna Gouldy

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



cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Sarah Hartmann, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Debra Amos-Terrell, Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
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Robin Hart, Associate Director, Risk Management Branch, CCHCS Regional
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Heather Pool, Chief Assistant Inspector General, OIG
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Amanda Elhardt, Report Coordinator, OIG



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
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Cycle 8
Medical Inspection Report
for
California State Prison, Solano

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
November 2026

OIG