Amarik K. Singh, *Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

February 2022

Cycle 6 Medical Inspection Report

Kern Valley State Prison

Revised on 3-8-22; see next page for explanation.

Report revised and republished on 3-8-21:

Footnote II in the HEDIS table was revised regarding sample size (page 11). One rating box color was adjusted on Table 1 (page 3).

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Introduction

Pursuant to California Penal Code section 6126 et seq., 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 persons[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide 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. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers 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.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

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

[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.

[4] The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.

[5] If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

The OIG has adjusted Cycle 6 reporting in two ways. First, commencing with this reporting period, we interpret compliance and case review results together, providing a more holistic assessment of the care; and second, we consider whether institutional medical processes lead to identifying and correcting provider or system errors. The review assesses the institution's medical care on both system and provider levels.

As we did during Cycle 5, our office is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of Kern Valley State Prison (KVSP), the receiver had not delegated this institution back to the department.

We completed our sixth inspection of KVSP, and herein present our assessment of the health care provided at KVSP during the inspection period between July 2020 and December 2020.[6] Our case reviews encompassed patients during the COVID-19 pandemic. The inspection was otherwise completed with no further adjustments.[7]

Located in Delano, Kern County, Kern Valley State Prison (KVSP) is a Level IV (maximum-security) facility consisting of four semiautonomous 180-bed facilities and two standalone administrative segregation units. KVSP operates several medical clinics where staff handle nonurgent requests for medical services. The institution also treats patients who need urgent or emergency care in its triage and treatment area (TTA) and treats patients who require inpatient care in their correctional treatment center (CTC). The institution screens patients in its receiving and release location (R&R) and provides specialized clinical services in its specialty service/telemedicine clinic. KVSP has been designated by CDCR as a *basic care institution*, as its location is rural, far from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients.

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[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include cardiopulmonary resuscitation (CPR) reviews between February 2020 and December 2020, non-CPR emergency reviews between April 2020 and December 2020, death reviews between November 2019 and January 2021, high-risk reviews between June 2020 and December 2020, hospitalization reviews between March 2020 and December 2020, transfer reviews between September 2020 and November 2020, and RN sick call reviews between June 2020 and April 2021.

[7] As of December 2, 2021, the department reports on its public tracker that 69 percent of its incarcerated population at KVSP is fully vaccinated while 64 percent of KVSP staff are fully vaccinated: see www.cdcr.ca.gov/covid19/population-status-tracking/.

Summary

The OIG completed the Cycle 6 inspection of Kern Valley State Prison (KVSP) in April 2021. OIG inspectors monitored the institution's delivery of medical care that occurred between July 2020 and December 2020.

The OIG rated the overall quality of health care at KVSP as ***inadequate***. We list the individual indicators and ratings applicable to this institution in Table 1 below.

Table 1. KVSP Summary Table

Health Care Indicators	Cycle 6 Case Review Rating	Cycle 6 Compliance Rating	Cycle 6 Overall Rating	Change Since Cycle 5
Access to Care	*Adequate*	*Inadequate*	*Inadequate*	↓
Diagnostic Services	*Inadequate*	*Inadequate*	*Inadequate*	↓
Emergency Services	*Inadequate*	*N/A*	*Inadequate*	↓
Health Information Management	*Adequate*	*Proficient*	*Adequate*	=
Health Care Environment	*N/A*	*Inadequate*	*Inadequate*	=
Transfers	*Adequate*	*Inadequate*	*Adequate*	=
Medication Management	*Adequate*	*Inadequate*	*Inadequate*	=
Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*	*N/A*
Preventive Services	*N/A*	*Inadequate*	*Inadequate*	↓↓
Nursing Performance	*Adequate*	*N/A*	*Adequate*	=
Provider Performance	*Adequate*	*N/A*	*Adequate*	=
Reception Center	*N/A*	*N/A*	*N/A*	*N/A*
Specialized Medical Housing	*Adequate*	*Proficient*	*Adequate*	=
Specialty Services	*Adequate*	*Inadequate*	*Inadequate*	↓
Administrative Operations†	*N/A*	*Inadequate*	*Inadequate*	↓

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 5 and Cycle 6. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Administrative Operations** is a secondary indicator and is not considered when rating the institution's overall medical quality.

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

To test the institution's policy compliance, our compliance inspectors, (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 415 patient records and 1,110 data points and used the data to answer 91 policy questions. In addition, we observed KVSP's processes during an on-site inspection in March 2021. Table 2 below lists KVSP average scores from Cycles 4, 5, and 6.

Table 2. KVSP Policy Compliance Scores

		Scoring Ranges		
		100%–85.0%	84.9%–75.0%	74.9%–0
Medical Inspection Tool (MIT)	**Policy Compliance Category**	**Cycle 4 Average Score**	**Cycle 5 Average Score**	**Cycle 6 Average Score**
1	Access to Care	93.3%	82.3%	62.8%
2	Diagnostic Services	61.1%	81.4%	55.8%
4	Health Information Management	65.7%	72.5%	90.9%
5	Health Care Environment	86.8%	73.7%	58.9%
6	Transfers	74.7%	66.9%	64.1%
7	Medication Management	71.9%	67.0%	38.5%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	90.1%	88.0%	55.3%
12	*Reception Center*	N/A	N/A	N/A
13	Specialized Medical Housing	96.0%	95.0%	85.0%
14	Specialty Services	74.5%	85.6%	68.2%
15	Administrative Operations	85.6%*	75.6%	68.7%

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

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

The OIG clinicians (a team of physicians and nurse consultants) reviewed 51 cases, which contained 1,058 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in April 2021 to verify their initial findings. The OIG physicians rated the quality of care for 22 comprehensive case reviews. Of these 22 cases, our physicians rated 20 ***adequate*** and two ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[8] Multiple OIG physicians and nurses 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. As noted above, we listed the individual indicators and ratings applicable to this institution in the KVSP Summary Table.

In February 2021, the Health Care Services Master Registry showed that KVSP had a total population of 3,615. A breakdown of the medical risk level of the KVSP population as determined by the department is set forth in Table 3 below.[9]

Table 3. KVSP Master Registry Data as of February 2021

Medical Risk Level	Number of Patients	Percentage
High 1	81	2.2%
High 2	204	5.6%
Medium	1,496	41.4%
Low	1,834	50.7%
Total	3,615	100.0%

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 02-12-21.

[8] The indicators for **Reception Center** and **Prenatal Care** do not apply to KVSP.

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

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, KVSP had zero vacant executive leadership positions, one vacant primary care provider position, 0.2 vacant nursing supervisor positions, and 1.6 vacant nursing staff positions.

Table 4. KVSP Health Care Staffing Resources as of February 2021

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5	8	11.2	84.6	108.8
Filled by Civil Service	5	7	11	83	106
Vacant	0	1	.2	1.6	2.8
Percentage Filled by Civil Service	100.0%	87.5%	98.2%	98.1%	97.4%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0%	0%	0%	0%	0%
Filled by Registry	0	0	0	0	0
Percentage Filled by Registry	0%	0%	0%	0%	0%
Total Filled Positions	5	7	11	83	106
Total Percentage Filled	**100.0%**	**87.5%**	**98.2%**	**98.1%**	**97.4%**
Appointments in Last 12 Months	1	0	2	13	16
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	0	1	1
Adjusted Total: Filled Positions	**5**	**7**	**11**	**83**	**106**
Adjusted Total: Percentage Filled	**100.0%**	**87.5%**	**98.2%**	**98.1%**	**97.4%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes 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 6 medical inspection pre-inspection questionnaire staffing matrix received February 12, 2021, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

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. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10]

The OIG did not find any adverse deficiencies at KVSP during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to KVSP. Of these 10 indicators, OIG clinicians rated eight ***adequate*** and two ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 22 detailed case reviews they conducted. Of these 22 cases, 20 were ***adequate*** and two were ***inadequate***. In the 1,058 events reviewed, there were 182 deficiencies, 24 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at KVSP:

- The institution provided excellent health care information management, as most hospital discharge records, diagnostic results, and specialty reports were retrieved and scanned within the required time frames.

Our clinicians found KVSP could improve in the following areas:

- The institution performed poorly in collecting laboratory samples and in retrieving pathology reports.

- The institution performed poorly in emergency care. Compared with Cycle 5, we reviewed the same number of events, but identified more deficiencies including multiple significant

[10] For a definition of an event, see Table A-1.

deficiencies. We found incomplete nursing assessments, interventions, and documentation.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to KVSP. Of these 10 indicators, our compliance inspectors rated two ***proficient***, and eight ***inadequate***. We tested policy compliance in the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators, as these indicators do not have a case review component.

KVSP demonstrated a high rate of policy compliance in the following areas:

- Medical staff performed well in scanning initial health care screening forms, community hospital discharge reports, and requests for health care services into patient's electronic medical records within required time frames.
- KVSP's specialized medical housing unit had properly working call buttons. Medical staff were able to enter patient rooms during emergent events in a timely manner.
- The institution's nursing staff and providers completed initial health care assessments, and history and physical evaluations within the required time frames.

KVSP demonstrated a low rate of policy compliance in the following areas:

- Staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to the specialized medical housing unit. Furthermore, there was poor medication continuity for patients transferring within the facility and patients who had a temporary layover at KVSP.
- Health care staff did not consistently follow proper hand hygiene precautions before or after patient encounters.
- Providers performed poorly with communicating diagnostic test results to patients.
- Nursing staff did not regularly inspect emergency medical response bags (EMRBs).

- The institution often failed to provide appointments for chronic care, specialty services, nursing referrals, and hospital discharge follow-ups within the specified time frame.

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 6. 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 Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered KVSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. KVSP's results compared favorably with those found in State health plans for diabetic care measures. We list the HEDIS measures in Table 5.

Comprehensive Diabetes Care

Statewide comparison data were available for only three of the five diabetic measures. When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal), KVSP outperformed the other programs in HbA1c screening and blood pressure control (two of three diabetic measures that include comparative data) and tied with Kaiser Southern California for poor HbA1c control. We include HbA1c control and eye examination data for information purposes.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. KVSP had a 28 percent influenza immunization rate for adults 18 to 64 years old, and a 72 percent immunization rate for adults 65 years and older.[11] The pneumococcal vaccine rate was 69 percent.[12]

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. KVSP had 70 percent colorectal cancer screening rate.

[11] The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result. The sample for older adults did not include a full sample.

[11] The pneumococcal vaccines administered are the 13 valent pneumococcal vaccine (PCV13) or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than where the patient was currently housed during the inspection period.

Table 5. KVSP Results Compared With State HEDIS Scores

HEDIS Measure	KVSP Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018 †	California Kaiser SoCal Medi-Cal 2018 †
HbA1c Screening	**100%**	90%	94%	96%
Poor HbA1c Control (> 9.0%) ‡, §	**18%**	34%	25%	**18%**
HbA1c Control (< 8.0%) ‡	**77%**	–	–	–
Blood Pressure Control (< 140/90) ‡	**87%**	65%	78%	84%
Eye Examinations	52%	–	–	–
Influenza – Adults (18–64)	28%	–	–	–
Influenza – Adults (65+) ‖	72%	–	–	–
Pneumococcal – Adults (65+) ‖	69%	–	–	–
Colorectal Cancer Screening	70%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in March 2021 by reviewing medical records from a sample of KVSP'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 the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2019–June 30, 2020 (published April 2021).

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

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

‖ For these measures the result was from a sample size fewer than 10.

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

Recommendations

As a result of our assessment of KVSP's performance, we offer the following recommendations to the department:

Access to Care

- Medical leadership should determine the root cause of challenges in the timely provision of chronic care follow-up appointments with providers, nurse-to-provider referrals, routine-priority specialty appointments and follow-up specialty appointments, and implement remedial measures as appropriate.

Diagnostic Services

- Medical leadership should ascertain causative factors related to the untimely provision of laboratory services and implement remedial measures as appropriate.
- Medical leadership should determine the root cause of challenges with notification and endorsement of STAT laboratory results and implement remedial measures as appropriate to ensure they are performed within required time frames.
- Medical leadership should ascertain causative factors with timely communication of pathology results to the patient and develop remedial measures as appropriate.
- The department should consider developing an electronic solution to ensure that providers create patient letters at the time of endorsement and the patient results letter auto populates accurately with all required elements per CCHCS policy.

Emergency Services

- Nursing leadership should determine the root cause of challenges that prevent nurses from completely and accurately documenting emergent events and should implement remedial measures as appropriate.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

Transfers

- The department should consider developing and implementing an electronic alert to ensure receiving and release (R&R) nurses properly and thoroughly complete initial health screening questions and follow up as needed.

- The department should consider defining a clear requirement regarding which fields within the electronic health record system (EHRS) transfer-out PowerForm must be completed for any patient transferring out.

Medication Management

- Medical and nursing leadership should ensure that new, chronic care, hospital discharge, and specialized medical housing patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.

Preventive Services

- Medical leadership should determine the cause of challenges related to screening patients yearly for tuberculosis (TB) and implement remedial measures as appropriate.

- Medical leadership should determine the root cause(s) of challenges in the timely provisions of chronic care vaccinations.

Provider Performance

- Institutional medical leadership should consider training to ensure improved population management meetings, which includes strategizing for better patient clinical outcomes.

Specialized Medical Housing

- Nursing leadership should determine the root cause of challenges preventing patients from receiving all ordered medications within the time frame required and implement remedial measures as appropriate.

Specialty Services

- Medical leadership should identify why preapproved specialty appointments were missed for transfer-in patients; leadership should implement remedial measures as appropriate.

- Medical leadership should identify the root cause in the timely provision of ordered specialty services and subsequent follow-up visits and implement remedial measures as appropriate.

- Medical leadership should ascertain the challenges in the receipt of specialty reports in the required time frames and implement remedial measures as appropriate.

- Medical leadership should determine the root cause of challenges in patient notification of denials within the required time frame and implement remedial measures as appropriate.

Access to Care

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

Overall Rating
Inadequate
Case Review Rating
Adequate
Compliance Score
Inadequate
(62.8%)

Results Overview

KVSP's performance in this indicator varied. OIG clinicians found most appointments were completed in a timely manner, including appointments with correctional treatment center (CTC) providers, nurses, and specialists. However, outpatient provider appointments often did not occur timely. Furthermore, compliance testing received an overall of 62.8 percent in this indicator. Therefore, KVSP's poor compliance performance was a significant factor in our rating this indicator ***inadequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 448 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. Of the nine deficiencies we found related to access to care, three were significant.[13]

Access to Clinic Providers

Access to clinic providers is an integral part of patient care in health care delivery, and KVSP performed poorly in ensuring provider appointments occurred within the required time frames. Compliance testing found that 68.0 percent of chronic care follow-up appointments occurred on time (MIT 1.001), 42.9 percent nurse-to-provider follow-up appointments occurred as requested (MIT 1.005), and zero percent of provider-ordered sick call follow-up appointments occurred as requested (MIT 1.006). The OIG clinicians reviewed 90 clinic provider appointments and identified two significant deficiencies, which are listed below:

[13] Deficiencies occurred twice in case 28, and once in cases 9, 11, 14, 18, 23, 29, and 31. Cases 9, 11, and 28 had significant deficiencies.

- In case 9, a provider requested a follow-up chronic care appointment within 14 days; however, the appointment occurred more than one month later.

- In case 11, a nurse evaluated a patient for back pain and requested a provider appointment within 14 days; however, the appointment occurred more than one month later.

Access to Specialized Medical Housing Providers

KVSP performed well in access to care in the CTC. When staff admitted the patient to the CTC, providers examined patients in a timely manner. Providers evaluated patients and documented their progress notes within appropriate time frames. Compliance testing found that 100 percent of the CTC admission history and physical examinations occurred within required time frame (MIT 13.002). OIG clinicians assessed 111 CTC provider encounters and did not identify any deficiencies related to a late or missed admission history and physical examinations or follow-up appointments.

Access to Clinic Nurses

KVSP performed well with access to nursing sick calls and provider-to-nurse referrals. Compliance testing found all nurse sick call requests were reviewed on the day they were received (MIT 1.003, 100%). Moreover, the nurses evaluated 86.7 percent of their patients within the required one business day (MIT 1.004). OIG clinicians identified four deficiencies related to clinic nurse access.[14] Two examples are listed below:

- In case 14, a provider requested a nursing appointment within five days to discuss the patient's noncompliance with his insulin regimens; however, the appointment did not occur until 10 days later.

- In case 28, a nurse triaged a patient complaining of weight gain and ordered a face-to-face encounter on the following day; however, the nursing sick call evaluation did not occur until 23 days later.

Access to Specialty Services

Compliance testing found that 86.7 percent of the initial high-priority specialty appointments occurred within required time frame (MIT 14.001), and 86.7 percent of the initial medium-priority specialty appointments as requested (MIT 14.004). However, the institution

[14] Deficiencies occurred once in cases 14, 28, 29, and 31.

performed poorly with the initial routine-priority specialty appointments (MIT 14.007, 66.7%). The institution also performed poorly overall with follow-up specialty appointments (MIT 14.003, 66.7%, MIT 14.006, 88.9%, and MIT 14.009, 28.6%). OIG clinicians reviewed 83 specialty events and identified one deficiency.[15]

Follow-Up After Specialty Service

KVSP performed adequately in ensuring patients saw their providers after specialty appointments. Compliance testing revealed that 74.2 percent of provider appointments after specialty services occurred within required time frames (MIT 1.008). OIG clinicians evaluated 83 specialty appointments and did not identify any missed or delayed provider appointments.

Follow-up After Hospitalization

KVSP performed poorly ensuring that patients saw their providers within the required time frames after hospitalizations. Compliance testing found that 70.0 percent of provider appointments occurred within required time frames (MIT 1.007). OIG clinicians reviewed 24 hospital returns and did not identify any missed or delayed provider appointments.

Follow-up After Urgent or Emergent Care (TTA)

KVSP providers generally saw their patients following a triage and treatment area (TTA) event as requested. OIG clinicians assessed 23 TTA events and identified one delay in a provider follow-up appointment, as described below:

- In case 23, TTA staff saw the patient for abdominal pain and the provider requested for a follow-up appointment within two days; however, the appointment occurred in three days.

Follow-up After Transferring Into the Institution

KVSP performed poorly in providing appointments for newly arrived patients within required time frames (MIT 1.002, 40.0%). OIG clinicians evaluated four transfer-in events and identified a delay in a nursing appointment: shown below:

[15] A deficiency occurred in case 28.

- In case 18, the patient was newly transferred in, and a nurse requested a nursing care manager appointment within 30 days; however, the appointment occurred in 39 days, nine days late.

Clinician On-Site Inspection

KVSP has five main clinics: facilities A, B, C, D, and M. Each clinic had two providers. Each clinic also had an office technician who attended the morning huddles and ensured that provider appointments were met. The scheduling supervisor explained that most of the delayed or missed appointments were related to the COVID-19 pandemic. During the peak of the pandemic, the office technicians scheduled about three to five urgent-emergent provider appointments per day. At the time of the clinician on-site inspection, providers had returned to their normal schedule of about ten appointments per day.

Compliance Testing Results

Table 6. Access to Care

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) *	17	8	0	68.0%
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) *	10	15	0	40.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
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) *	26	4	0	86.7%
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) *	3	4	23	42.9%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	0	1	29	0
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	14	6	1	70.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	23	8	14	74.2%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	5	1	0	83.3%
			Overall percentage (MIT 1): **62.8%**	

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	NA	NA	NA	NA
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	NA	NA	NA	NA
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *	0	0	10	NA
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	4	3	66.7%
Did the patient receive the medium-priority specialty service within 15–45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	8	1	6	88.9%
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) *	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	5	8	28.6%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still had state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

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

Recommendations

- Medical leadership should determine the root cause of challenges in the timely provision of chronic care follow-up appointments with providers, nurse-to-provider referrals, routine-priority specialty appointments and follow-up specialty appointments, and implement remedial measures as appropriate.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's ability to timely complete radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's ability to timely complete and review immediate (stat) laboratory tests.

Overall Rating
Inadequate
Case Review Rating
Inadequate
Compliance Score
Inadequate
(55.8%)

Results Overview

Overall, KVSP needed to improve in this indicator. Although, the institution performed well in completing and retrieving radiology tests, it performed poorly in collecting laboratory samples and notifying stat laboratory results to providers. The institution also performed poorly in communicating test results to patients. Because both case review and compliance assigned low scores, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 244 diagnostic events and identified 29 deficiencies,[16] two of which were considered significant.[17]

Test Completion

KVSP performed poorly in completing laboratory tests. Compliance testing found that 60.0 percent of laboratory tests were completed within requested time frames (MIT 2.004). Our clinicians reviewed 202 laboratory tests and identified four deficiencies related to missed or delayed lab completion.[18] Two examples are listed below:

- In case 9, a provider requested laboratory tests be completed on the same day; however, the laboratory tests were completed four days later.
- In case 29, a provider requested a laboratory test be completed on the following day; however, the test was not done.

Compliance testing found the institution did not consistently collect stat laboratory samples or receive stat test results within required time frames (MIT 2.007, 50.0%). Nursing staff also performed poorly in notifying providers within one hour of receiving stat laboratory test results or providers did not acknowledge stat test results within

[16] Deficiencies occurred five times in case 9, four times in cases 8 and 31, twice in cases 2, 11, 13, 14, 24, 28, and 32, and once in cases 26 and 29.

[17] Significant deficiencies occurred in cases 13 and 29.

[18] Deficiencies occurred in cases 2, 9, 13, and 29.

required time frames (MIT 2.008, 25.0%). Our clinicians reviewed one stat laboratory record; the test was completed in a timely manner, and a provider acknowledged the test result within required time frames.

Compliance testing showed the institution completed most radiology tests within required time frames (MIT 2.001, 80.0%). OIG clinicians reviewed 23 radiology tests and identified no deficiencies.

Health Information Management

Compliance testing showed providers endorsed most radiology and laboratory reports timely (MIT 2.002, 90.0%, and MIT 2.005, 80.0%). Providers also endorsed stat laboratory results within required time frames (MIT 2.009, 75.0%). Our clinicians identified 12 deficiencies related to deficient or delayed endorsement of laboratory results.[19] Two examples are listed below:

- In case 8, the provider did not endorse laboratory test results including a thyroid stimulating hormone level.
- In case 24, the provider did not endorse a COVID-19 test result.

Compliance testing showed providers did not thoroughly communicate results of radiology studies or laboratory tests to patients (MIT 2.003, 30.0%, and MIT 2.006, 10.0%). Our clinicians found that on four occasions, a provider did not send a laboratory result letter,[20] and on seven occasions, providers did not include all key required elements in the patients' letters.[21]

Compliance testing showed that KVSP retrieved 80.0 percent of pathology reports within required time frames (MIT 2.010). Providers endorsed most pathology reports within required time frames (MIT 2.011, 90.0%); however, providers did not send results letters to their patients within required time frames (MIT 2.012, zero). Our clinicians reviewed two biopsy events and found that one pathology report was not retrieved, as described below:

- In case 13, the patient had a rectal biopsy, and the pathology report was not retrieved.

Clinician On-Site Inspection

[19] Deficiencies occurred twice in cases 8, 9, 28, and 32, and once in cases 2, 14, 24, and 31.

[20] Missing patient's laboratory result letter occurred twice in cases 8 and 31.

[21] Missing test dates in the letters occurred twice in case 9, and once in cases 11, 14, 24, 26, and 31.

KVSP had several phlebotomists on staff, four full-time and one part-time, who were assigned to the four main clinics, M yard, the TTA, and the CTC. The laboratory vendor communicated stat laboratory results with TTA staff, who informed the provider of the results.

The diagnostic services supervisor informed OIG clinicians that the laboratory vendor placed laboratory results into the electronic health record system (EHRS) and notified providers for review and endorsement.

Compliance Testing Results

Table 8. Diagnostic Services

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) *	8	2	0	80.0%
Radiology: Did the ordering 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 communicate the results of the radiology study to the patient within specified time frames? (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) *	6	4	0	60.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	8	2	0	80.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	2	2	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	3	0	25.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	3	1	0	75.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **55.8%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Recommendations

- Medical leadership should ascertain causative factors related to the untimely provision of laboratory services and implement remedial measures as appropriate.
- Medical leadership should determine the root cause of challenges with notification and endorsement of STAT laboratory results and implement remedial measures as appropriate to ensure they are performed within required time frames.
- Medical leadership should ascertain causative factors with timely communication of pathology results to the patient and develop remedial measures as appropriate.
- The department should consider developing an electronic solution to ensure that providers create patient letters at the time of endorsement and the patient results letter auto populates accurately with all required elements per CCHCS policy.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; we did not perform compliance testing for this indicator.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Results Overview

KVSP's performance was unsatisfactory for emergency services. We reviewed the same number of events as we did for Cycle 5, but identified more deficiencies including multiple significant deficiencies. KVSP delivered poor emergency care for patients with chest pain, as providers did not always order appropriate medications for patients with chest pain. We also identified a pattern of deficiencies for incomplete nursing assessments, interventions, and documentation. In addition, EMRCC and nursing supervisors did not always identify these deficiencies in their clinical review of emergent events. The OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 23 urgent and emergent events and found 22 emergency care deficiencies, five of which were significant.[22]

Emergency Medical Response

KVSP staff responded promptly to emergencies throughout the institution. Staff initiated CPR, activated emergency medical services, and notified TTA staff timely.

Provider Performance

On-call providers were available for consultation with TTA staff and documented their telephone calls with nurses. However, our clinicians

[22] Deficiencies occurred three times in cases 7, 23 and 29, twice in cases 1, 2, 4, 10, and 24, and once in cases 5 and 11. Significant deficiencies occurred twice in cases 7 and 29, and once in case 1.

identified two opportunities for improvement related to chest pain management, as shown in the examples below:

- In case 7, the patient with cardiac risk factors complained of chest pain. The provider ordered aspirin but did not order nitroglycerin.
- In case 29, the patient complained of chest pain. The provider ordered aspirin but did not order nitroglycerin.

Nursing Performance

KVSP nurses performed poorly during emergency events. We identified a pattern of incomplete nursing assessments and interventions, especially for patients presenting with chest pain. The following are examples:

- In case 1, the patient complained of severe chest pain. The EKG showed possible obstruction of blood flow to the heart. The TTA nurse administered nitroglycerin but did not reassess the patient's chest pain until 22 minutes later at which time the patient reported continued severe chest pain. The nurse should have reassessed the patient's chest pain within five minutes and should have given an additional dose of nitroglycerin. This oversight placed the patient at risk for cardiac complications.
- In case 24, the patient had an unwitnessed fall with loss of consciousness, head trauma, severe chest pain, and shortness of breath; however, the TTA nurse did not place the patient in cervical spine immobilization or reassess the patient's chest pain.
- In case 29, the patient complained of moderate chest pain. The EKG showed a possible obstruction of blood flow to the heart, but the nurse did not promptly administer nitroglycerin and aspirin after the provider ordered them. In addition, the nurse did not reassess the patient's chest pain to determine if the nitroglycerin was effective.

Nursing Documentation

Nursing documentation showed room for improvement. Our clinicians identified six documentation deficiencies.[23] Nurses did not always document administered medications on the medication administration record. There were time-line discrepancies related to the sequence of

[23] Deficiencies occurred in cases 2, 4, 5, 7, 23, and 29.

emergency events, and pertinent information was missing. The following are examples:

- In cases 2, the nurse administered a medication to treat a possible narcotic overdose but did not document it on the medication administration record.
- In case 29, the patient complained of chest pain. The nurse noted that the patient's vital signs were obtained; however, the nurse did not document the readings.

Emergency Medical Response Review Committee

Compliance testing showed that the EMRRC did not perform initial reviews within required time frames (MIT 15.003, 58.3%). Our clinicians identified eight deficiencies related to either the committee or the nursing supervisors not identifying nursing deficiencies, or not completing a review of emergent events.[24]

Clinician On-Site Inspection

The TTA maintained three beds, and the patient care area had sufficient space to provide emergency care. Two RNs and a provider staffed the unit. Nurses reported having a good rapport and collaborative working relationship with custody staff. We discussed some of the case review findings with nursing leadership, who informed us that additional training would be provided.

Recommendations

- Nursing leadership should determine the root cause of challenges that prevent nurses from completely and accurately documenting emergent events and should implement remedial measures as appropriate.

[24] Deficiencies occurred twice in cases 10 and 23, and once in cases 1, 4, 7, and 24.

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 clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Proficient*** **(90.9%)**

Results Overview

KVSP performed well in health information management with both compliance and case review. We found that medical staff retrieved and scanned most hospital discharge records, diagnostic results, and specialty reports in a timely manner. Overall, the OIG rated this indicator ***adequate.***

Case Review and Compliance Testing Results

OIG clinicians reviewed 1,058 events and found five deficiencies related to health information management, one of which was significant.[25]

Hospital Discharge Reports

KVSP performed well in retrieving and scanning hospital records. Compliance testing found that KVSP staff retrieved and scanned hospital discharge records within required time frames (MIT 4.003, 89.5%). Most discharge records included the important physician discharge summary, and providers endorsed reports within five days (MIT 4.005, 95.0%). Our clinicians reviewed 24 hospital events and did not identify any deficiencies.

Specialty Reports

KVSP performed well in retrieving and reviewing specialty reports. Compliance testing showed that 86.7 percent of specialty reports were scanned within required time frame (MIT 4.002). KVSP providers generally reviewed high-priority, medium-priority, and routine-priority specialty reports within required time frames (MIT 14.002, 86.7%, MIT 14.005, 75.0%, and MIT 14.008, 53.9%).

[25] Deficiencies occurred twice in case 13, and once in cases 11, 23, and 26. A significant deficiency occurred in case 13.

Our clinicians reviewed 83 specialty reports and identified one deficiency, as shown below:

- In case 23, the pulmonologist's consultation was scanned into the medical record; however, the provider did not review the consultation until 12 days later.

Diagnostic Reports

KVSP proficiently retrieved and endorsed diagnostic reports. Compliance testing showed providers endorsed radiology and laboratory reports within required time frames (MIT 2.002, 90.0%, and MIT 2.005, 80.0%).

Compliance testing found staff retrieved pathology reports within required time frames (MIT 2.010, 80.0%), and providers endorsed pathology reports within specified time frames (MIT 2.011, 90.0%). Our clinicians found one out of two pathology reports were retrieved in a timely manner; the missing pathology report is discussed in the **Diagnostic Services** indicator.

Urgent and Emergent Records

Our clinicians reviewed 23 emergency care events and found nurses and providers recorded these events sufficiently. Our clinicians did not identify any deficiencies.

Scanning Performance

KVSP performed adequately with the scanning process. Compliance testing showed the institution properly scanned, labeled, and named medical files (MIT 4.004, 83.3%). Our clinicians identified one mislabeled document, listed below:

- In case 11, a magnetic resonance imaging (MRI) result was filed with the incorrect date.

Clinician On-Site Inspection

Medical staff at KVSP's central medical records office scanned records on receipt. Most patients returning from the community hospital had their hospital records with them. TTA nurses were instructed to contact the hospital directly for any missing hospital records.

The laboratory vendor directly entered laboratory results into the EHRS. For on-site specialty reports, on-site specialty nurses scanned reports on the same day the visit occurred. For off-site specialty reports, medical record staff scanned the handwritten reports on the day the

visit occurred and the formal specialty reports as they were received. Specialty nurses also contacted specialists directly for any missing specialty reports.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	17	2	2	89.5%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	20	4	0	83.3%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	19	1	1	95.0%
			Overall percentage (MIT 4):	**90.9%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Table 10. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	8	2	0	80.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008) *	1	3	0	25.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	9	3	3	75.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	7	6	2	53.9%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Recommendations

The OIG had no specific 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' ability to maintain 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, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians did not rate this indicator.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(58.9%)

Results Overview

For this indicator, KVSP's performance declined compared with its performance in Cycle 5. In the present cycle, multiple aspects of KVSP's health care environment needed improvement: multiple clinics contained expired medical supplies; multiple clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment; emergency medical response bag (EMRB) logs either were missing staff verification or inventory was not performed; and staff did not regularly sanitize their hands before or after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

We examined outdoor patient waiting areas (see Photo 1, next page). Health care and custody staff reported that existing waiting areas had sufficient seating capacity and were only used to practice social distancing when the indoor waiting areas were at capacity. Staff reported only calling patients to come to the building close to their appointed time during inclement weather.

Photo 1. Outdoor waiting area (photographed on March 4, 2021).

Indoor Waiting Areas

We inspected indoor waiting areas (see Photo 2, next page). Patients had enough seating capacity while waiting for their appointments. Depending on the population, patients were either placed in a holding area or held in individual modules (see Photo 3, next page) to await their medical appointments. These holding areas had temperature control, running water, and toilets, but not all clinic waiting areas had hand sanitation items such as antiseptic soaps. We also observed patients not wearing or not properly wearing their masks, and not socially distancing while in the waiting area (see Photo 4, page 39). We did not notice health care staff or custody staff educating patients regarding this matter.

Photo 2. Indoor waiting area (photographed on March 4, 2021).

Photo 3. Individual waiting module (photographed on March 3, 2021).

Photo 4. Patients not socially distanced and either not wearing a face mask or not wearing face mask properly (photographed on March 4, 2021).

Clinic Environment

Of the 10 clinic environments, nine were sufficiently conducive to medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 90.0%). In one clinic, the triage station did not provide reasonable auditory privacy.

Of the 10 clinics we observed, seven contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 70.0%). The three remaining clinics had one or more of the following deficiencies: the examination room lacked visual and auditory privacy for conducting clinical examinations (see Photo 5, next page), the examination room lacked adequate space (fewer than 100 square feet), and the clinic's examination room table had a torn cover.

Photo 5. Examination room did not provide reasonable visual privacy.
In addition, patient was not wearing face mask properly (photographed on March 4, 2021).

In addition to the above findings, our compliance inspectors observed the following in clinics or examination rooms when they conducted their on-site inspection:

- In the R&R common room for medical supplies, we found cabinet drawers were missing (see Photo 6, next page). We interviewed the clinic nurse and the clinic supervisor; both were unaware of the missing cabinet drawers. In addition, at the time of our inspection, there were no evidence that staff had submitted a work order for repair or replacement.

Photo 6. R&R missing medical supply cabinet drawers (photographed on March 4, 2021).

Clinic Supplies

Only one of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 10.0%). We found one or more of the following deficiencies in nine clinics: expired medical supplies (see Photo 7, below, and Photos 8 and 9, on the following page), unidentified medical supplies, cleaning materials stored with medical supplies, staff members' personal items and food stored with medical supplies, medical supplies stored directly on the floor, and compromised sterile medical supply packaging.

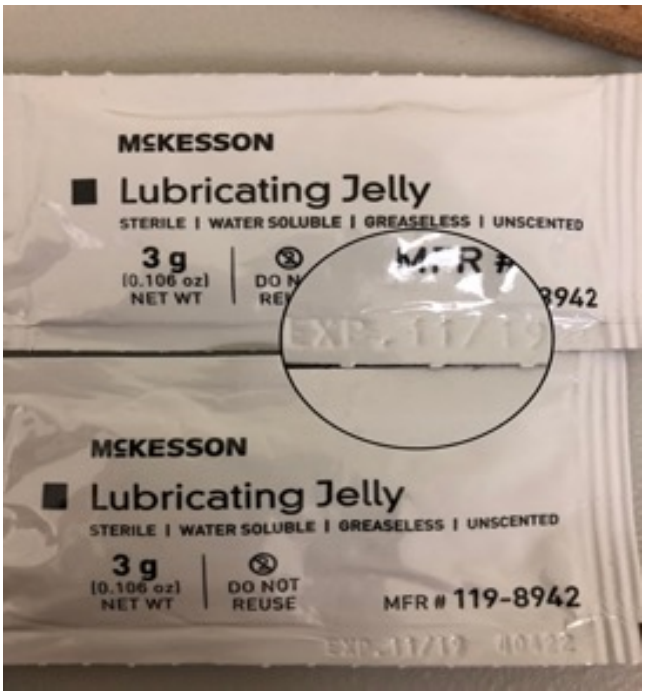

Photo 7. Expired medical supplies dated November 2019 (photographed on March 5, 2021).

Photo 8. Expired medical supplies dated August 2020 (photographed on March 4, 2021).

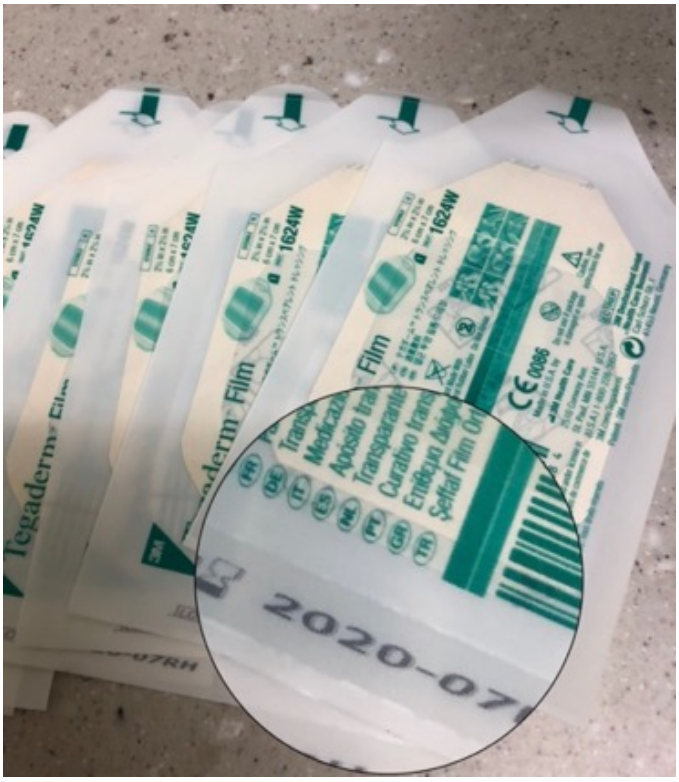

Photo 9. Expired medical supplies dated July 2020 (photographed on March 5, 2021).

Only one of the 10 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 10.0%). The remaining nine clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. Missing items included a hemoccult card, lubricating jelly, examination table disposable paper, oto-ophthalmoscope, tips for otoscope, tongue depressors, and an examination table. The staff had not properly calibrated an oto-ophthalmoscope, a weight scale, and a nebulizer. We found a nonfunctional oto-ophthalmoscope, and expired hemoccult cards and lubricating jelly. We also noted the Snellen eye chart was placed at an improper distance (see Photo 10). Moreover, KVSP staff did not properly log the results of the defibrillator performance test within the last 30 days.

Photo 10. The Snellen eye chart was placed at an improper distance of 22 feet and 10 inches. The proper distance is 20 feet (photographed on March 3, 2021).

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only two of the eight EMRBs passed our test (MIT 5.111, 25.0%). We found one or more of the following deficiencies with six EMRBs: staff failed to ensure the EMRBs'

compartments were sealed and intact, staff either had not inventoried the EMRBs when seal tags were replaced or had not inventoried the EMRBs in the previous 30 days, an EMRB lacked an oxygen wrench, and an EMRB had an oxygen tank with a nonfunctioning regulator; when it was replaced, the tank pressure showed 800 psi (see Photo 11).

Photo 11. EMRB oxygen tank pressure at 800 psi (photographed on March 5, 2021).

In addition to the above findings, our compliance inspectors observed the following in clinics or examination rooms when they conducted their on-site inspection:

- In the administrative segregation unit (ASU), we found a damaged biohazardous sharps wall mount that left the sharps container stored insecurely and easily accessible (see Photo 12, next page). We interviewed the clinic nurse and the clinic supervisor; both were not aware of the broken biohazardous wall mount. In addition, at the time of our inspection, there was no evidence that staff submitted a work order for repair or replacement.

Photo 12. Damaged biohazardous sharps wall mount (photographed on March 4, 2021).

In the R&R, we found durable medical equipment (DME) such as a bilevel positive airway pressure (BiPAP) machine and eyeglasses stored for patients who had already transferred out from KVSP to a different institution, which dated to 2019. On further review of the patients' electronic health records, both patients had received replacement DME from the receiving institution.

Medical Supply Management

All medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, 100%). According to the chief executive officer (CEO), KVSP did not have any concerns about the medical supplies process. Health care managers and medical warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected seven of 10 clinics (MIT 5.101, 70.0%). In three clinics, we found one or more of the following deficiencies: cleaning logs were not maintained, biohazardous waste was not emptied from the previous day, and the treatment room was not free of grime and dust build-up (see Photo 13).

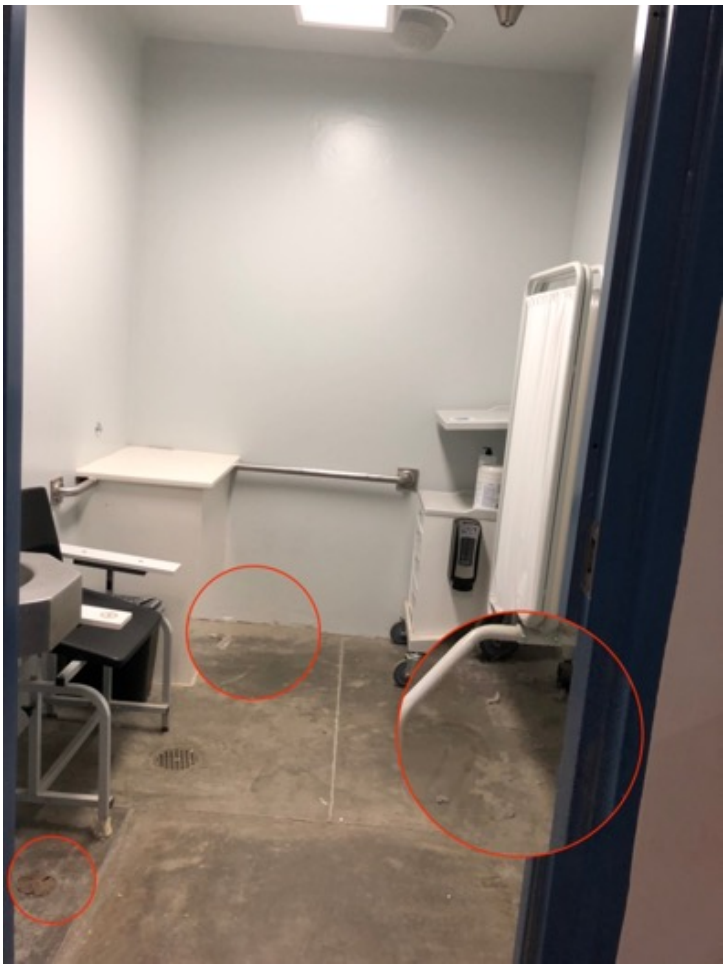

Photo 13. Treatment room was not free of grime and dust build-up (photographed on March 3, 2021).

Staff in eight of 10 clinics (MIT 5.102, 80.0%) properly sterilized or disinfected medical equipment. In two clinics, staff relied on inmate porters or did not mention disinfecting the examination table as part of their daily start-up protocol.

We found operating sinks and hand hygiene supplies in the examination rooms in seven of 10 clinics (MIT 5.103, 70.0%). The patient restrooms in three clinics lacked antiseptic soap.

We observed patient encounters in six clinics. In four clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, or before performing blood draws (MIT 5.104, 33.3%).

Health care staff in nine of 10 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 90.0%). In one clinic, we found an unsecured full sharps container stored in the biohazard bin.

Physical Infrastructure

KVSP's health care management and plant operations manager reported all clinical areas infrastructures were in good working order and did not hinder health care services.

At the time of our medical inspection, the institution had no ongoing health care facility improvement program (HCFIP) construction projects (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	7	3	0	70.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	8	2	0	80.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	7	3	0	70.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	4	4	33.3%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	1	0	90.0%
Warehouse, conex, and other nonclinic 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)	1	9	0	10.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	1	9	0	10.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	1	0	90.0%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	7	3	0	70.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	2	6	2	25.0%
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 is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 5): **58.9%**			

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Recommendations

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

- Nursing leadership should direct each clinic nursing supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

Transfers

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(64.1%)**

In this indicator, OIG inspectors examined the transfer process for 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 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 if staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the ability of staff to communicate vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed if staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

KVSP had mixed performance in this indicator. Compared with Cycle 5, KVSP had both fewer and less significant case review deficiencies. Our clinicians found KVSP performed well with the transfer-in process, and KVSP's transfer-out process was also sufficient. Compliance testing received an overall score of 64.1 percent, mainly due to poor scores received for initial health care screenings, whereby R&R nurses did not perform these assessments thoroughly for patients transferred from other CDCR institutions. Compliance also found interruptions in medication continuity for patients returning from the hospital or emergency room. After reviewing all aspects of the **Transfers** indicator, the OIG rated this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed 31 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified eight deficiencies, one of which was significant.[26]

[26] Deficiencies occurred twice in cases 23 and 26, and once in cases 18, 19, 21, and 22. A significant deficiency occurred in case 26.

Transfers In

We found KVSP's transfer-in process to be sufficient. Although the compliance team found R&R nurses did not complete the initial health screening form thoroughly (MIT 6.001, zero), the nurses performed well in addressing signs and symptoms when screening for tuberculosis (MIT 6.002, 100%). OIG clinicians reviewed four transfer-in cases and found R&R nurses evaluated newly arrived patients and requested provider appointments within appropriate time frames.

The compliance team found medication continuity at the time of transfer was good (MIT 6.003, 92.3%). Our clinicians did not identify any deficiencies related to medication continuity.

When patients transferred into KVSP with preapproved specialty services, compliance testing found that 35.0 percent of specialty appointments were completed within required time frames (MIT 14.010). Our clinicians did not identify any missed or delayed preapproved specialty appointments.

Transfers Out

KVSP's transfer-out process was satisfactory. Our clinicians reviewed four transfer-out cases and found nurses completed face-to-face evaluations prior to transfer and identified two deficiencies related to incomplete intrafacility transfer forms.[27] One example is listed below:

- In case 21, the nurse did not thoroughly complete the intra facility transfer form. Therefore, pertinent information such as the patient's pending X-ray was not documented.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room were at high-risk for lapses in care quality. These patients typically experienced severe illness or injury and required more care; successful health information transfer was necessary for good quality care. Any transfer lapse can result in serious consequences for these patients. KVSP performed well in retrieving and reviewing hospital records (MIT 4.003, 89.5% and MIT 4.005, 95.0%). Our clinicians reviewed 24 hospital or emergency room returns and did not identify any deficiencies.

KVSP showed opportunities for improvement in providing follow-up appointments within required time frame to patients returning from

[27] Deficiencies occurred in cases 21 and 22.

the hospital or from emergency room visits (MIT 1.007, 70.0%). In contrast, our clinicians did not identify any deficiencies.

Compliance testing showed that KVSP performed poorly in medication continuity (MIT 7.003, 57.9%). Our clinicians identified two deficiencies related to medication continuity, one of which was considered significant.[28] This significant deficiency is discussed in the **Medication Management** indicator.

Clinician On-Site Inspection

Our clinicians interviewed the R&R nurses, who were knowledgeable about their job duties and the transfer process. We were informed that all patients who transferred in or who returned from an off-site hospitalization were placed on COVID-19 surveillance for 14 days prior to returning to the general population.

[28] Deficiencies were identified in cases 23 and 26. A significant deficiency occurred in case 26.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answers			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	0	25	0	0
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	25	0	0	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	12	1	12	92.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	NA	NA	NA	NA
Overall percentage (MIT 6): **64.1%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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) *	10	15	0	40.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	14	6	1	70.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	17	2	2	89.5%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	19	1	1	95.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	11	8	2	57.9%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	17	8	0	68.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	2	5	0	28.6%
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) *	7	13	0	35.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Recommendations

- The department should consider developing and implementing an electronic alert system to ensure (receiving and release) R&R nurses properly and thoroughly complete initial health care screening questions and follow up as needed.

- The department should consider defining a clear requirement regarding which fields within the electronic health record system (EHRS) transfer-out PowerForm must be completed for any patient who transfers out.

Medication Management

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(38.5%)

In this indicator, OIG inspectors evaluated the institution's ability to administer 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. When rating this indicator, the OIG strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

Overall, KVSP performed poorly in medication management. Compliance testing had an overall score of 38.5 percent, which represented a significant decrease from the Cycle 5 score of 67.0 percent. We identified opportunities for improvement in newly prescribed medications, chronic care medications, hospital medications, and specialized medical housing medications. On the other hand, we found that KVSP performed well with medication continuity for patients transferring into the institution. After considering all factors, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 137 events related to medications and found 18 medication deficiencies, four of which were significant.[29]

New Medication Prescriptions

Compliance testing found new mediations were not available or administered timely (MIT 7.002, 60.0%). Our clinicians also found a pattern of missed or late administration of newly ordered medications. Two examples follow:

- In case 11, the patient did not receive his newly ordered steroid medication. In addition, the patient received his antireflux medication five days late.
- In case 27, the patient did not receive his newly prescribed medication to treat an upset stomach.

[29] Deficiencies occurred four times in case 26, three times in case 11, twice in case 31, and once in cases 2, 7, 10, 23, 24, 27, 28, 29, and 40. Significant deficiencies occurred cases 2, 11, 26, and 27.

Chronic Medication Continuity

Compliance testing found patients did not receive their chronic care medications within required time frames (MIT 7.001, 11.8%). In contrast, our clinicians found patients received their chronic care medications timely.

Hospital Discharge Medications

KVSP performed poorly in ensuring patients received their medications when they returned from an off-site hospital or emergency room. Compliance testing found when patients returned from an off-site hospital or emergency room, they did not receive their medications within the required time frame (MIT 7.003, 57.9%). Our clinicians reviewed 24 hospital returns and found two deficiencies related to medication management.[30] An example is listed below:

- In case 26, the patient returned from a community hospital and received his blood pressure medications and multivitamin one day late.

Specialized Medical Housing Medications

Medication performance in specialized medical housing was poor. Compliance testing found when patients were admitted to the correctional treatment center (CTC), medications were not administered timely (MIT 13.004, 60.0%). Our clinicians found seven deficiencies related to specialized medical housing medications.[31] The following is an example:

- In case 2, the patient did not receive three doses of his antibiotic.

Transfer Medications

Both compliance testing and case review found that KVSP performed well with medication continuity for patients transferring into the institution (MIT 6.003, 92.3%). However, the same finding did not apply when patients transferred within the institution (MIT 7.005, 68.0%).

[30] Deficiencies occurred in cases 23 and 26.

[31] Deficiencies occurred three times in case 26, twice in case 11, and once in cases 2 and 10.

Medication Administration

Our clinicians found the vast majority of nurses administered medications properly. Compliance testing did not review any tuberculosis (TB)-adminstered medications (MIT 9.001).

Clinician On-Site Inspection

Our clinicians interviewed medication nurses and found they were knowledgeable about the medication process, they attended clinic huddles, and they notified providers of expiring medications. We also met with the pharmacist and nursing leadership to discuss some of our findings. Nursing leadership reported that they would provide training.

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in seven of 10 clinic and medication line locations (MIT 7.101, 70.0%). In two locations, nurses could not describe the narcotic medication discrepancy reporting process. In the remaining clinic, narcotic medications were not properly securely stored as required by CCHCS policy.

KVSP appropriately stored and secured nonnarcotic medications in eight of 11 clinic and medication line locations (MIT 7.102, 72.7%). In three locations, we observed one or more of the following deficiencies: staff did not have an effective inventory process to account for medications stored in the Omnicell, the medication storage cabinet was disorganized, and the medication area lacked a clearly labeled designated area for medications that were to be returned to the pharmacy.

Staff kept medications protected from physical, chemical, and temperature contamination in five of the 11 clinic and medication line locations (MIT 7.103, 45.5%). In six locations, we observed one or more of the following deficiencies: staff did not record or did not consistently record the room temperatures, the medication refrigerator was unsanitary, and staff did not separate the storage of oral and topical medications (see Photos 14 and 15, following page).

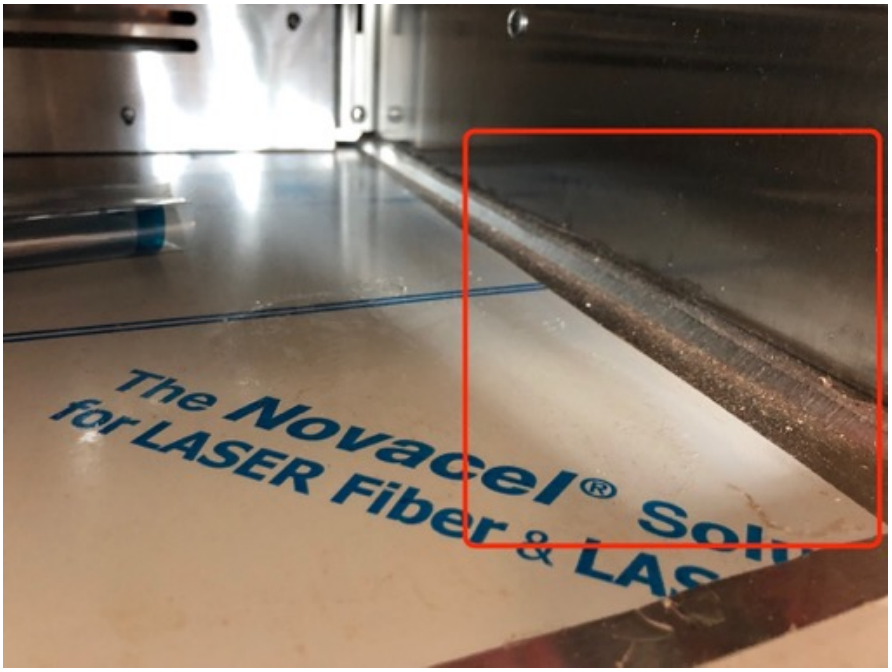

Photo 14: Unsanitary medication refrigerator (photographed March 5, 2021).

Photo 15: Oral and topical medications not stored separately (photographed March 2, 2021).

Staff successfully stored valid, unexpired medications in seven of the 11 applicable medication line locations (MIT 7.104, 63.6%). In four locations, we observed one or both of the following deficiencies: medication nurses failed to label the multiuse medication as required by CCHCS policy, and medication was stored beyond the expiration date (see Photos 16 and 17).

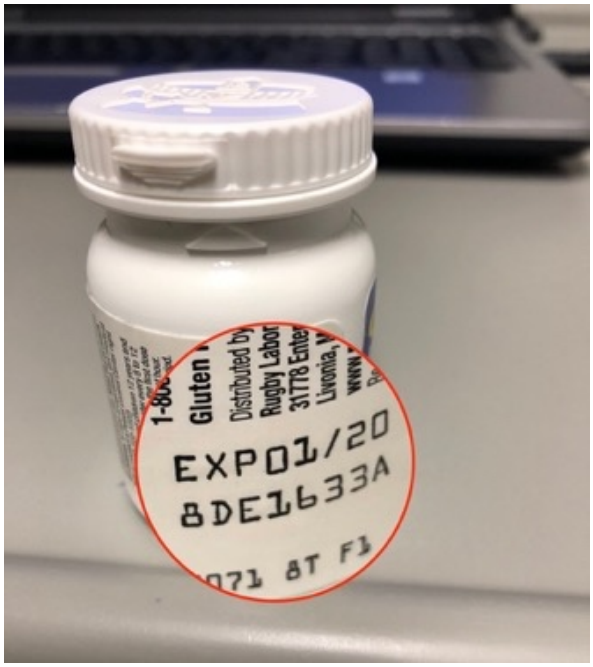

Photo 16. Expired nonrefrigerated medication dated January 2021 (photographed on March 5, 2021).

Photo 17. Expired refrigerated medication dated February 2021 (photographed on March 4, 2021).

Nurses exercised proper hand hygiene and contamination control protocols in one of six locations (MIT 7.105, 16.7%). In four locations, some nurses neglected to wash or sanitize their hands before each subsequent regloving. In one location, the medication nurse often sanitized the same pair of gloves worn and did not reglove when necessary.

Staff in three of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 42.9%). In four locations, we observed one or both of the following deficiencies: medication nurses did not maintain nonissued medication in its original labeled packaging (see Photo 18), and medication nurses did not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order.

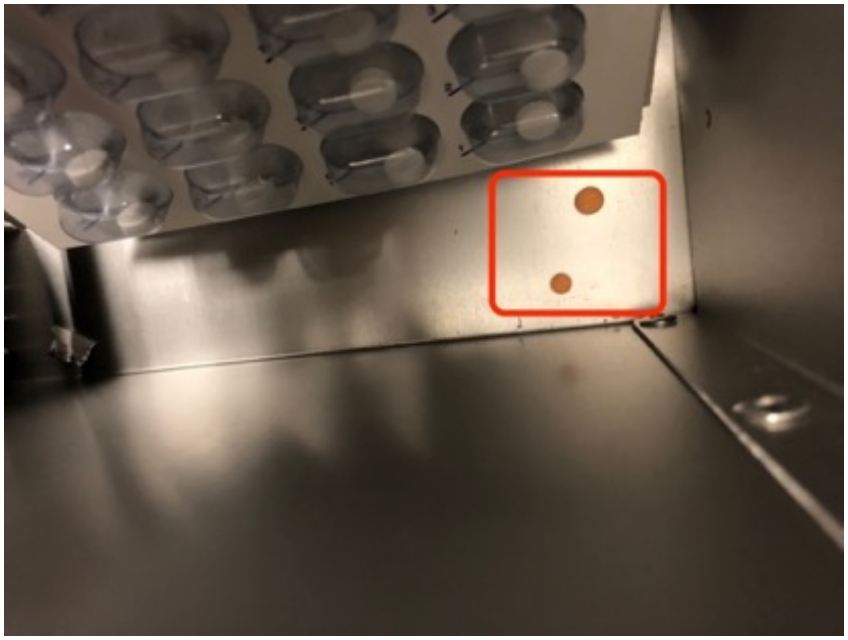

Photo 18. Medication not kept in its original labeled packaging (photographed on March 3, 2021).

Staff in one of six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 16.7%). In five locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the time frame of one hour before or one hour after the normal distribution time; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; medication nurses discarded empty medication

bubble packs that showed patient information in the trash bin (see Photo 19, below); nurses could not describe the medication error reporting process; medication nurses did not appropriately administer medication as ordered by the provider; and nurses did not follow insulin protocols properly.

Medication nurses did not record the performed quality-control check of the glucometer used in checking patients' fingerstick blood sugar levels on the diabetic line (see Photo 20, on the following page). During insulin administration, we observed some medication nurses did not properly disinfect the vial's port prior to withdrawing medication. In addition, a medication nurse administering insulin did not compare the drawn unit dose from the MAR prior to administration.

Photo 19. Discarded empty medication bubble packs with patient information in the trash bin (photographed on March 3, 2021).

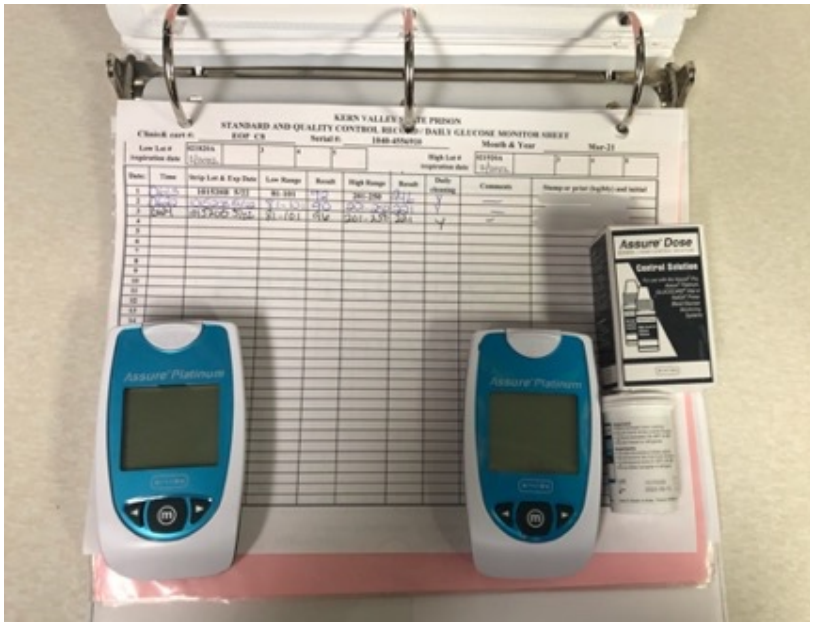

Photo 20. Only one of two diabetic line glucometer's quality control was performed and logged (photographed on March 3, 2021).

In addition to the above findings, our compliance inspectors observed the following issues with medication practices or storage during their on-site inspection:

- In the R&R, we found parole medications that were not given to the patients when they were paroled. These medications were warfarin sodium (an anticoagulant) (see Photo 21 on the following page) and hydroxyzine pamoate (an antianxiety medication). The patients' parole dates were in February 2021 and in November 2020, respectively. The institution did not have a system in place to store and ensure parole patients had received their medications upon release. In addition, staff did not return the undelivered parole medication to the pharmacy.

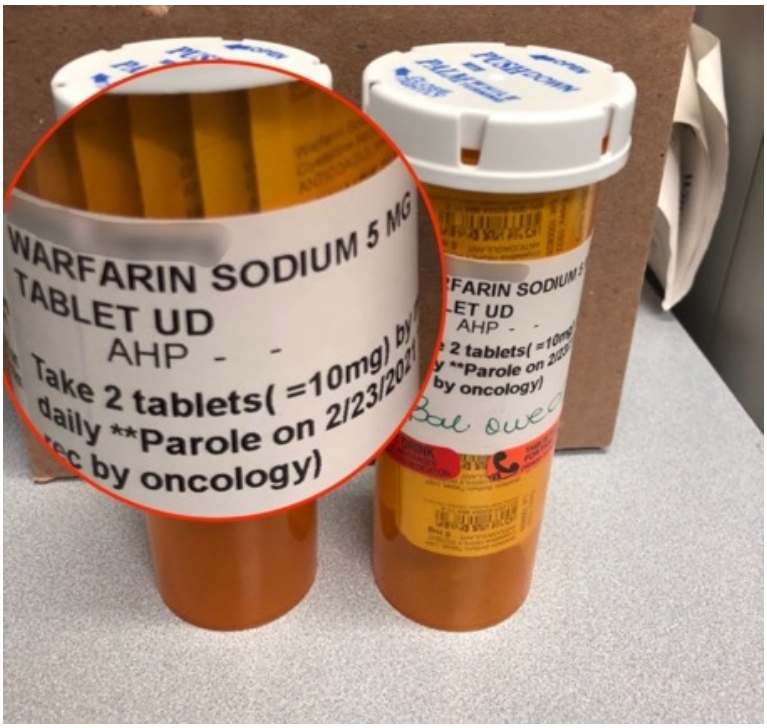

Photo 21. Parole medication not received by the patient upon release nor returned to pharmacy (photographed on March 4, 2021).

Pharmacy Protocols

KVSP did not follow general security, organization, and cleanliness management protocols in its main and remote pharmacies (MIT 7.108, zero). More specifically, the pharmacy doors were not kept locked to prevent unauthorized entry at the time of inspection (see Photos 22 and 23, on the following page).

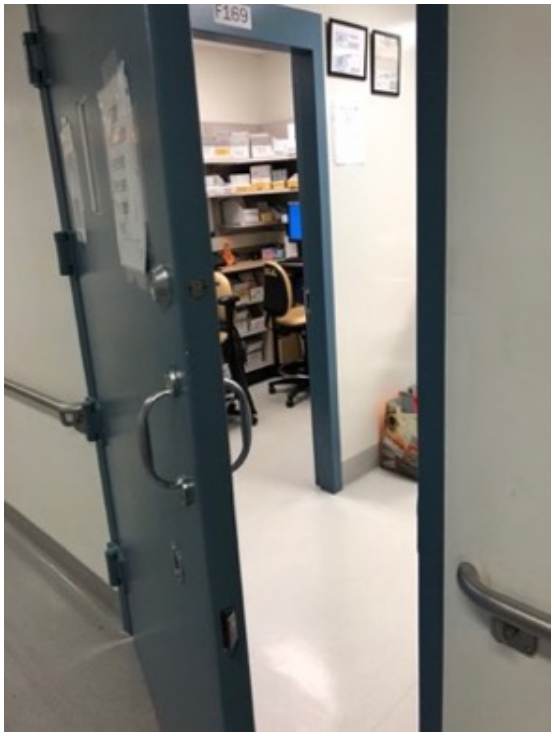

Photo 22. Pharmacy doors were not kept locked to prevent unauthorized entry (photographed on March 4, 2021).

Photo 23. Pharmacy doors were not kept locked to prevent unauthorized entry (photographed on March 4, 2021).

In its main pharmacy, staff did not properly store nonrefrigerated medication. Staff stored bulk food items within the medication preparation area (see Photos 24 and 25). As a result, KVSP received a score of zero in this test (MIT 7.109).

Photo 24. Bulk/long-term food items stored within the medication preparation area (photographed March 3, 2021).

Photo 25. Bulk/long-term food items stored within the medication preparation area (photographed on March 3, 2021).

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

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC and nurses present at the time of the medication-area inspection did not correctly complete several medication-area inspection checklists (CDCR Form 7477). These errors resulted in a score of zero in this test (MIT 7.111).

We examined 24 medication error reports. For 22 reports, the PIC was not able to provide evidence that a pharmacy error follow-up review was performed. For the remaining two reports, we found one or more of the following deficiencies: the PIC did not document that the patient had been notified, and the PIC did not document the recommended changes to correct the medication error. As a result, KVSP received a score of zero in this test (MIT 7.112).

Nonscored Tests

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 KVSP, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in restrictive housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Of the applicable patients interviewed, 17 of 20 indicated they had access to their rescue medications. The remaining three patients reported they did not have their prescribed rescue inhaler. Patients verbalized that the medication was taken away and placed in their property when transferred to the restrictive housing unit. We promptly notified the CEO of this concern. The CEO and the PIC reported the need for a patient medication refill request to be completed before issuing the rescue inhaler replacement. As a result, rescue medications were not immediately reissued to the patients, but were reissued the next day (MIT 7.999).

Compliance Testing Results

Table 14. Medication Management

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) *	2	15	8	11.8%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	15	10	0	60.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	11	8	2	57.9%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	NA	NA	NA	NA
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	17	8	0	68.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	2	5	0	28.6%
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)	7	3	1	70.0%
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	3	0	72.7%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	5	6	0	45.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	7	4	0	63.6%
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)	1	5	5	16.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	3	4	4	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	1	5	5	16.7%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	0	24	0	0
Pharmacy: 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 is a non-scored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue	This is a non-scored test. Please see the indicator for discussion of			

inhalers and nitroglycerin medications? (7.999)	this test.
	Overall percentage (MIT 7): **38.5%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	12	1	12	92.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	NA	NA	NA	NA
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	NA	NA	NA	NA
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	NA	NA	NA	NA
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	6	4	0	60.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Recommendations

- Medical and nursing leadership should ensure that new, chronic care, hospital discharge, and specialized medical housing patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.

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 high risk for coccidioidomycosis (valley fever), we tested the institution's ability to transfer out patients quickly. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians did not rate this indicator.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(55.3%)

Results Overview

KVSP staff experienced mixed performance in preventive services. Staff performed well in offering patients an influenza vaccine for the most recent influenza season and were proficient in offering colorectal cancer screenings for patients ages 50 through 75. On the other hand, they faltered when offering required immunizations to chronic care patients, in screening patients annually for TB, and in timely transferring out patients who were at the highest risk of coccidioidomycosis (valley fever) infection. These findings are set forth in the table on the next page. We rated this indicator ***inadequate***.

Compliance Testing Results

Table 16. Preventive Services

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)	NA	NA	NA	NA
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	NA	NA	NA	NA
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	15	10	0	60.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	21	4	0	84.0%
All patients from the age of 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	22	3	0	88.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	NA	NA	NA	NA
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	NA	NA	NA	NA
Are required immunizations being offered for chronic care patients? (9.008)	8	10	7	44.4%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	0	3	0	0
			Overall percentage (MIT 9):	**55.3%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the EHRS PowerForm for tuberculosis symptom monitoring.

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

Recommendations

- Medical leadership should determine the cause of challenges related to screening patients yearly for tuberculosis (TB) and implement remedial measures as appropriate.
- Medical leadership should determine the root cause(s) of challenges in the timely provision of chronic care vaccinations.

Nursing Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' ability to make timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance in 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 overall 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**.

Results Overview

Nurses at KVSP generally provided appropriate nursing care. The number of deficiencies we found in this indicator were fewer than those we found in Cycle 5, including significant deficiencies. We identified opportunities for improvement in several areas of the nursing process described in the sections below. Considering all these factors, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 229 nursing encounters in 50 cases. Of the nursing encounters we reviewed, 117 were in the outpatient setting. We identified 89 nursing performance deficiencies, 10 of which were significant.[32]

Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interview) and

[32] Deficiencies occurred thirteen times in case 26, eight times in cases 2 and 24, seven times in case 11, six times in case 31, five times in cases 29 and 30, three times in cases 10, 23 and 28, twice in cases 1, 8, 27 and 39, and once in cases 4, 5, 9, 12, 13, 17, 19, 21, 22, 36, 37, 40, 41, 42, 44, 45, 46, 47, 50 and 51. Significant deficiencies occurred twice in case 29 and once in cases 1, 10, 26, 27, 30, 39, 46 and 47.

objective (observation and examination) elements. KVSP nurses generally provided appropriate nursing assessments and interventions.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. KVSP nurses generally documented their care appropriately. However, emergency services and transfers showed room for improvement, which we discuss in the **Emergency Services** and **Transfers** indicators. The following are examples of outpatient documentation deficiencies:

- In case 1, the nurse administered the influenza vaccine, but did not document the manufacturer, lot number, or expiration date. This information was important in the event the vaccine is recalled.

- In case 51, the nurse obtained the patient's oxygen level, but did not document the reading.

Nursing Sick Call

Our clinicians reviewed 34 sick call requests. The nurses saw on average 12 patients per day, and staff reported no appointment backlog. Most nurses performed appropriate assessments and interventions. However, the following are examples of deficiencies identified:

- In case 31, the patient complained of a fever and cough. The sick call nurse did not assess the patient on the same day for COVID-19 symptoms.

- In case 46, the patient had a possible medication reaction with mouth pain, difficulties drinking water and eating, and swollen tonsils. The sick call nurse did not assess the patient on the same day. When the nurse performed the assessment on the next business day, the nurse did not obtain a blood pressure, listen to the lungs, or document the appearance of the patient's tonsils.

Emergency Services

We reviewed 23 urgent or emergent events. The nurses responded promptly to emergent events. However, their assessments, interventions, and documentation showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 24 events that involved returns from off-site hospitals or emergency rooms. The nurses performed good nursing assessments, which we detailed further in the **Transfers** indicator.

Transfers

We reviewed seven cases that involved the transfer-in and the transfer-out processes. Nurses evaluated patients appropriately and initiated provider appointments within appropriate time frames. However, nurses did not always document pertinent information when patients transferred out of the institution. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed 10 CTC cases. Nurses provided satisfactory nursing care, which we detail further in the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 12 cases in which patients returned from off-site specialty appointments. Nurses performed good assessments, reviewed specialists' findings and recommendations, and communicated those results to providers. The **Specialty Services** indicator provides further information.

Medication Management

We reviewed 29 cases and found most nurses administered patients' medications as prescribed. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

Our clinicians spoke with nurses and nurse managers in the TTA, CTC, R&R, specialty service, outpatient clinic and medication areas. Nursing staff reported nursing morale was generally good. We attended organized clinic huddles and met with nursing leadership to discuss some of our case review findings. Nursing leadership thoroughly addressed our findings and acknowledged several opportunities for quality improvement.

Recommendations

We offer no specific recommendations for this indicator.

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care the institution's providers (physicians, physician assistants, and nurse practitioners) delivered. Our clinicians assessed the institution's providers' ability to evaluate, diagnose, and manage their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. The OIG assessed provider care through case review only and performed no compliance testing for this indicator.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Results Overview

Providers at KVSP delivered good patient care. They generally made appropriate assessments and decisions, managed chronic medical conditions effectively, reviewed medical records thoroughly, and addressed specialists' recommendations adequately. Even so, we observed an ineffective medical population management meeting at our on-site inspection. Taken together, the OIG rated this indicator ***adequate***.

Case Review Results

During our inspection, we found a total of 49 deficiencies, four of which were significant.[33] Most deficiencies were related to providers either not endorsing diagnostic reports within required time frames or thoroughly completing patient letters informing them of diagnostic results. OIG physicians also rated the overall adequacy of care for each of the 22 detailed case reviews they conducted. Of these 22 cases, 20 were adequate and two were inadequate.

Assessment and Decision-Making

KVSP providers generally made appropriate assessments and sound medical plans for their patients. They diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to proper specialists. Our clinicians identified one significant deficiency related to poor assessment and decision-making, as noted in the following:

[33] Deficiencies occurred seven times in cases 9 and 26, six times in case 31, five times in case 24, four times in cases 8 and 14, three times in case 32, twice in cases 12, 15, 27, and 28, and once in cases 2, 7, 11, 29, and 47. Significant deficiencies occurred twice in case 26, and once in cases 7 and 27.

- In case 27, a provider evaluated the patient for bright red stool; however, the provider did not perform a rectal exam or order a test for a possible occult gastrointestinal bleed.

Review of Records

For patients returning from hospitalizations, KVSP providers performed well in reviewing medical records and addressing the hospital recommendations. Providers also performed well in reviewing the MAR and in reconciliating patient medications.

Emergency Care

KVSP providers made appropriate triage decisions when the patients arrived at the TTA for emergency treatment. In addition, providers were available for consultation with TTA nursing staff. We identify two deficiencies related to emergency care,[34] which are discussed in the **Emergency Services** indicator.

Chronic Care

KVSP providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. KVSP designated two providers to the institution's substance use disorder treatment program. Our clinicians identified one significant deficiency related to poor diabetic management:

- In case 26, the patient had poorly controlled diabetes, and the provider did not review the glucose logs or titrate his insulin regimens to reach glycemic goals.

Specialty Services

KVSP providers appropriately referred and reviewed specialty reports in a timely manner, and providers adequately addressed specialists' recommendations. We identified one deficiency in which the provider did not address the specialist's recommendation:

- In case 32, the provider did not address the specialist's recommendation to give cranberry juice with each meal to prevent urinary tract infection.

[34] Deficiencies occurred in cases 7 and 29.

Documentation Quality

KVSP providers generally documented outpatient and TTA encounters on the same day of the encounter. Our clinician identified two deficiencies related to a lack of or inadequate provider documentation.[35] An example is listed below:

- In case 12, a provider prescribed an antibiotic, but did not document the reason for doing so.

Provider Continuity

KVSP assigned providers to specified clinics to ensure continuity of care. Our clinicians did not identify any issues related to provider continuity.

Clinician On-Site Inspection

At the time of the on-site inspection, KVSP had 11 full time providers including five on-site providers, two mid-level providers, and four telemedicine providers. KVSP had one provider vacancy. The providers were assigned to specified clinics to ensure continuity of care. Two providers were assigned to the substance use disorder treatment program; KVSP had about 700 patients participating in the opioid addiction treatment program.

KVSP's chief medical executive (CME) had been assigned to the headquarters substance use disorder treatment program; thus, the institution had not had an on-site CME for the past 18 months. The chief physician and surgeon (CP&S) had been at the institution for about 15 months. The OIG interviewed seven providers, four of whom held negative opinions of the CP&S. They expressed concerns about the CP&S's work ethic, clinical acumen, and communication skills. These providers stated the CP&S did not communicate with them directly, but instead relied on an office technician to communicate with them. One provider handed a written complaint against the chief P&S to our clinicians. The OIG has since forwarded the complaint to CCHCS leadership for further investigation.

OIG clinicians attended a bimonthly population health management meeting at clinic B. The meeting was run by a nurse, who presented health care measures on a desktop computer monitor. Custody staff, nursing staff, the clinic provider, and the CP&S attended the meeting. The meeting facilitator was poorly prepared and ineffective. For

[35] Deficiencies occurred in cases 12 and 15.

example, the nurse repeatedly referenced information unrelated to KVSP. Those in attendance appeared disinterested. No one offered suggestions for corrective action even when the facilitator reported the provider appointment backlog and poor compliance scores for chronic disease measures, such as for hemoglobin A1c.[36] Our clinicians were left with the impression that KVSP did not hold population health management meetings regularly, and the medical staff did not know the reasons for the meetings.

Recommendations

- Institutional medical leadership should consider training to ensure improved population management meetings, which includes strategizing for better patient clinical outcomes.

[36] The hemoglobin A1c test that reflects the patient's average of the blood sugar level over the past three months.

Specialized Medical Housing

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Proficient
(85.0%)

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. KVSP's specialized medical housing was a correctional treatment center (CTC). Our clinicians focused on medical staff's ability to assess, monitor, and intervene for medically complex patients requiring close medical supervision. Inspectors evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff's ability to respond promptly when patients' conditions deteriorated. Our clinicians looked for good communication when staff consulted with one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator.

Results Overview

KVSP performed sufficiently in this indicator. Compared with Cycle 5, KVSP improved, with fewer and less significant clinical deficiencies overall. KVSP providers scored well in completing history and physical exams within required time frames. Our clinicians found nurses performed appropriate admission assessments and rounds, and providers provided adequate care. KVSP had an overall compliance score of 85.0 percent. Most compliance deficiencies in the CTC were related to delays in the CTC nurse's initial admission assessments and medication availability. Overall, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed five CTC cases, which included both provider and nursing events. We identified 36 deficiencies, five of which were significant.[37]

Provider Performance

KVSP providers delivered *adequate* patient care. Compliance testing showed providers completed all admission history and physical examinations without delay (MIT 13.002, 100%). Our clinicians found providers generally made appropriate assessments and decisions, reviewed medical records thoroughly, and addressed specialists' recommendations timely. We identified six deficiencies; two of which

[37] Deficiencies occurred 21 times in case 26, five times in cases 2 and 11, four times in case 10, and once in case 28. Significant deficiencies occurred three times in case 26, and once in cases 2 and 10.

were significant.[38] The two significant deficiencies are discussed in the **Provider Performance** indicator.

Nursing Performance

Compliance testing showed CTC nurses completed 80.0 percent of initial admissions within required time frames (MIT 13.001). Our clinicians found CTC nurses performed timely admission assessments, conducted rounds, and generally provided satisfactory care. Our clinicians identified 23 deficiencies related to nursing care; two of which were significant.[39] Two examples are listed below:

- In case 11, nurses documented the patient had a rash, but did not consistently record the location and characteristics of the rash.
- In case 26, the patient's oxygen saturation was abnormally low; however, the nurse did not listen to the patient's lungs for abnormal air flow or consult a provider.[40]

Medication Administration

KVSP's CTC staff performed poorly in medication administration. Compliance testing showed 60.0 percent of newly admitted patients received their medications within required timeframes (MIT 13.004). Our clinicians identified seven deficiencies related to medication management; one was considered significant.[41] We discuss these in the **Medication Management** indicator.

Clinician On-Site Inspection

The institution's CTC had 12 medical beds, eight of which were negative pressure rooms. Our compliance testing found the call light system was functional (MIT 13.101, 100%). KVSP had a designated CTC provider who made rounds with nursing staff and conducted daily morning huddles.

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[38] All the deficiencies occurred in case 26.

[39] Deficiencies occurred twelve times in case 26, four times in case 2, three times in cases 10 and 11, and once in case 28. Significant deficiencies occurred in cases 10 and 26.

[40] Oxygen saturation is a vital parameter to define the lungs capability to deliver oxygen to the body tissues.

[41] Deficiencies occurred three times in case 26, twice in case 11, and once in cases 2 and 10. A significant deficiency occurred in case 2.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	8	2	0	80.0%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	NA	NA	10	NA
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	6	4	0	60.0%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
For specialized health care housing (CTC, SNF, Hospice, OHU): 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	NA
			Overall percentage (MIT 13):	**85.0%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still have state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

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

Recommendations

- Nursing leadership should determine the root cause of challenges preventing patients from receiving all ordered medications within the required time frame and implement remedial measures as appropriate.

Specialty Services

Overall Rating
Inadequate
Case Review Rating
Adequate
Compliance Score
Inadequate
(68.2%)

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's ability to provide 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.

Results Overview

KVSP's performance in this indicator was mixed. Although KVSP provided good access to initial specialty services, the institution faltered in follow-up specialty service appointments. The institution also performed poorly in scheduling preapproved specialty services appointments for patients who transferred into KVSP. Compliance testing received an overall score of 68.2 percent. Due to the COVID-19 pandemic, there were movement restrictions and some delays in face-to-face consultations. Factoring together compliance testing and case review findings, we rated this indicator as ***inadequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 130 events related to specialty services, including 83 specialty consultations and procedures, and found nine deficiencies.[42]

Access to Specialty Services

Compliance testing showed KVSP generally completed high-priority specialty, medium-priority specialty, and routine-priority specialty appointments within required time frames (MIT 14.001, 86.7%, MIT 14.004, 86.7%, and MIT 14.007, 66.7%). However, the institution performed poorly in high-priority and routine-priority follow-up specialty appointments (MIT 14.003, 66.7%, and MIT 14.009, 28.6%). The institution performed well in medium-priority follow-up specialty appointments (MIT 14.006, 88.9%). Our clinicians identified a delayed specialty appointment, described below:

- In case 28, a provider requested a follow-up appointment with the substance use disorder treatment clinic within 30 days; however, the appointment occurred in 56 days.

[42] Deficiencies occurred twice in cases 2 and 23, and once in cases 13, 26, 28, 30, and 32.

Our compliance testing found the institution performed poorly in scheduling preapproved specialty services appointments for patients who transferred into KVSP (MIT 14.010, 35.0%). In contrast, our clinicians assessed four transfer-in events and did not identify any missed or delayed preapproved specialty appointments.

Provider Performance

KVSP providers generally appropriately referred and reviewed specialty reports within recommended time frames and addressed specialists' recommendations. We identified one deficiency related to a provider who did not address all the specialists' recommendations.[43] The deficiency is discussed in the **Provider Performance** indicator.

Nursing Performance

Nurses at KVSP performed well. Specialty nurses reviewed requests for specialty services and appropriately arranged for specialty appointments. Nurses performed appropriate nursing assessments when patient returned from their specialty appointments. They reviewed specialists' findings and recommendations and communicated those results to providers. Nurses also obtained orders and requested provider follow-up appointments. We reviewed 24 nursing encounters related to specialty services and identified five deficiencies related to poor nursing assessments or plans.[44] An example is below:

- In case 23, the patient returned from an orthopedic visit with a new short arm cast; however, the nurse did not provide patient education related to symptoms of possible compartment syndrome.[45]

Health Information Management

KVSP performed adequately in retrieving and reviewing specialty reports. Compliance testing showed that medical staff retrieved and scanned 86.7 percent of specialty reports within required time frames (MIT 4.002). KVSP providers generally reviewed high-priority, medium-priority, and routine-priority specialty reports within required time frames (MIT 14.002, 86.7%, MIT 14.005, 75.0%, and MIT 14.008, 53.9%).

[43] A deficiency occurred in case 32.

[44] Deficiencies occurred twice in case 2, and once in cases 13, 23, and 30.

[45] Compartment syndrome is a medical condition with increased pressure in a confined body space such as a muscle compartment in the leg or the forearm.

Our clinicians did not identify any missing specialty reports, but they did identify a delay in a provider's review.[46]

Clinician On-Site Inspection

The institution employed multiple staff for on-site, off-site, and telemedicine specialty services, and staff had a tracking process to ensure all specialty appointments were completed within requested time frames. Three office technicians were assigned to support the on-site, off-site, and telemedicine specialty services, respectively. They tracked specialty reports and would contact specialists if the reports were not available.

[46] A delayed review occurred in case 23.

Compliance Testing Results

Table 18. Specialty Services

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) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	4	3	66.7%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	9	3	3	75.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	8	1	6	88.9%
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) *	10	5	0	66.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	7	6	2	53.9%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	5	8	28.6%
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) *	7	13	0	35.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	16	0	1	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	7	9	1	43.8%
			Overall percentage (MIT 14):	**68.2%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

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

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	23	8	14	74.2%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%

* The OIG clinicians considered these compliance tests along with their own case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following most specialty services. As a result, we test 1.008 only for high-priority specialty services or when the staff orders PCP or PC RN follow-ups. The OIG continues to test the clinical appropriateness of specialty follow-ups through its case review testing.

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

Recommendations

- Medical leadership should identify why preapproved specialty appointments were missed for transfer-in patients; leadership should implement remedial measures as appropriate.
- Medical leadership should identify the root cause in the timely provision of ordered specialty services and subsequent follow-up visits and implement remedial measures as appropriate.
- Medical leadership should ascertain the challenges in the receipt of specialty reports in required time frames, and implement remedial measures as appropriate.
- Medical leadership should determine the root cause of challenges in patient notification of denials within the required time frame, and implement remedial measures as appropriate.

Administrative Operations

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(68.7%)

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. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined if the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians did not rate this indicator.

Because none of the tests in this indicator affected clinical patient care directly (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Results Overview

KVSP's performance was mixed in this indicator as the institution scored well in some applicable tests, but faltered in others. The Emergency Medical Response Review Committee (EMRRC) did not review the cases timely and did not always complete the required checklists. The local governing body (LGB) or its equivalent did not regularly meet quarterly and discuss local operating procedures and any applicable policies. In addition, the institution conducted medical emergency response drills with incomplete documentation. Nurse and physician managers did not always complete annual performance appraisals in a timely manner. These findings are set forth in the table on the next page. Overall, we rated this indicator ***inadequate***.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. There were 10 unexpected (Level 1) deaths that occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of the death. After the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven calendar days after completion. In our

inspection, we found the DRC completed three death review reports promptly. The DRC finished two reports 75 to 138 days late and submitted them to the institution's CEO nine to 71 days after that. The remaining five reports were overdue at the time of the OIG's inspection (MIT 15.998).

Compliance Testing Results

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	NA	NA	NA	NA
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	7	5	0	58.3%
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? (15.004)	1	3	0	25.0%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	2	1	0	66.7%
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	9	1	0	90.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	1	9	0	10.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	4	0	42.9%
Did the providers maintain valid state medical licenses? (15.106)	15	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	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? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a non-scored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a non-scored test. Please refer to Table 4 for CCHCS- provided staffing information.			
	Overall percentage (MIT 15): **68.7%**			

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

Recommendations

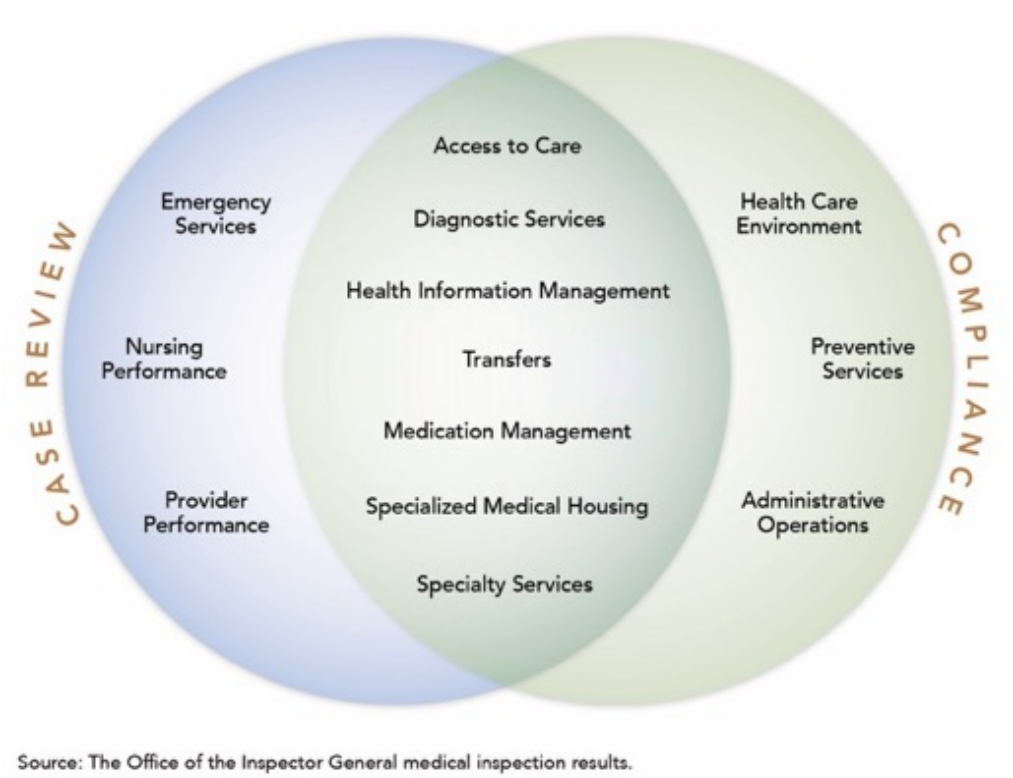
The OIG offered no specific recommendations for this indicator.

Appendix A. Methodology

In designing the medical inspection program, the OIG met with stakeholders to review 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 department, 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 A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Review Distribution for KVSP



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. 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, non-clinician 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.

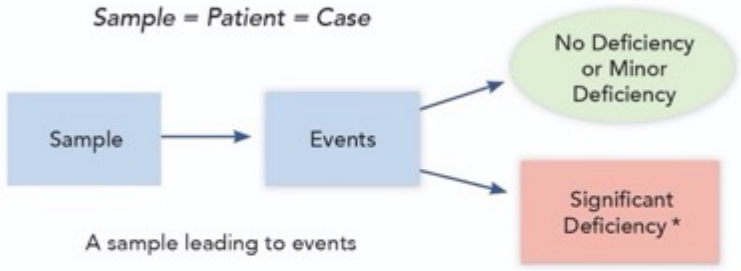
Case Review Testing Methodology

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 A–2 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.

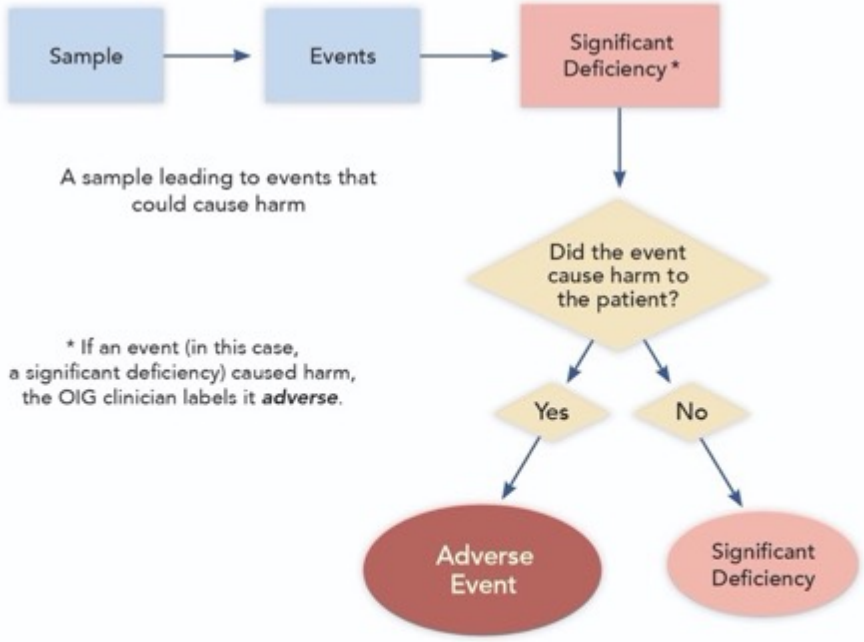
Figure A–2. Case Review Testing

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***.



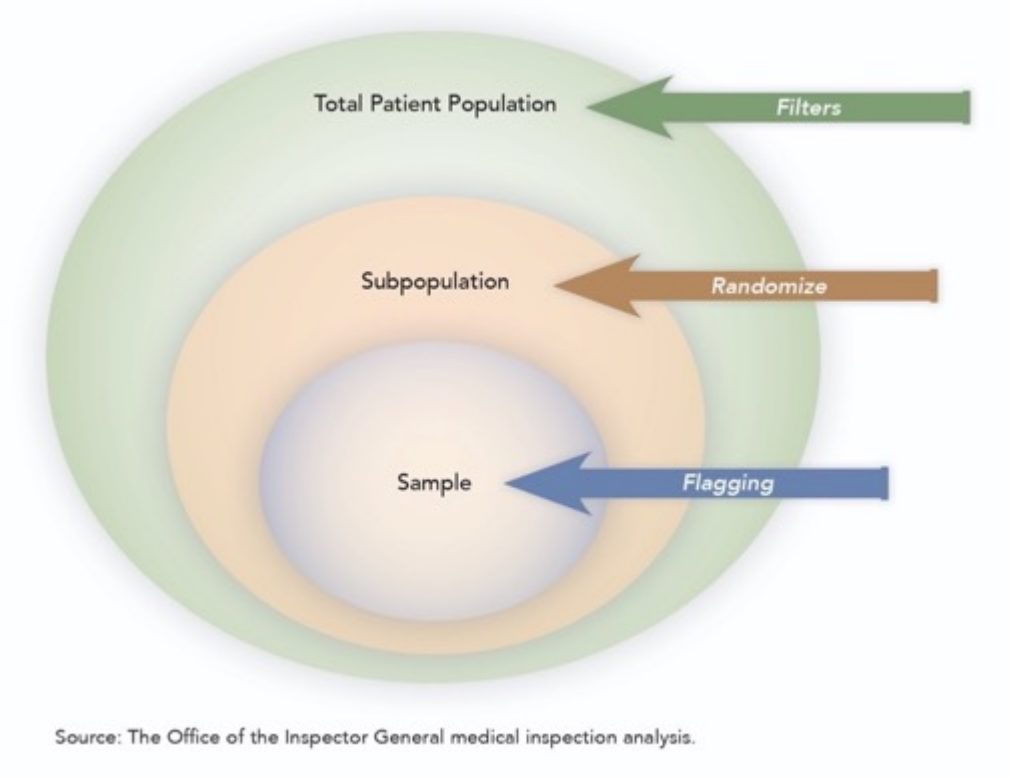
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a ***Yes*** or a ***No*** answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other documents, and obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

Our compliance team calculates the percentage of all Yes answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

Appendix B. Case Review Data

Table B–1. Kern Valley State Prison Case Review Sample Sets

Sample Set	Total
Anticoagulation	2
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	18
Specialty Services	2
	51

Table B–2. Kern Valley State Prison Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	3
Anticoagulation	2
Arthritis/Degenerative Joint Disease	6
Asthma	11
COPD	2
COVID-19	8
Cancer	2
Cardiovascular Disease	3
Chronic Kidney Disease	2
Chronic Pain	21
Cirrhosis/End-Stage Liver Disease	3
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	8
Gastroesophageal Reflux Disease	7
Gastrointestinal Bleed	2
Hepatitis C	17
Hyperlipidemia	17
Hypertension	19
Mental Health	25
Seizure Disorder	3
Sleep Apnea	3
Substance Abuse	19
Thyroid Disease	4
	190

Table B–3. Kern Valley State Prison Case Review Events by Program

Diagnosis	Total
Diagnostic Services	292
Emergency Care	28
Hospitalization	42
Intra-System Transfers In	9
Intra-System Transfers Out	6
Not Specified	1
Outpatient Care	360
Specialized Medical Housing	190
Specialty Services	130
	1,058

Table B–4. Kern Valley State Prison Case Review Sample Summary

MD Reviews Detailed	22
MD Reviews Focused	0
RN Reviews Detailed	13
RN Reviews Focused	29
Total Reviews	64
Total Unique Cases	51
Overlapping Reviews (MD & RN)	13

Appendix C. Compliance Sampling Methodology

Kern Valley State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	21	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	4	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	21	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	21	CADDIS Off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intra-system Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	0	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	21	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intra-facility Moves	25	MAPIP transfer data	• Date of transfer (2–8 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	7	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	24	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	20	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	0	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	0	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 (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • 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 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)

MIT 9.009	Valley Fever	3	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101 - 102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Service 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, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Service 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, and radiology services • Randomize

MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Service 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, and radiology 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	17	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	N/A	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	7	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	15	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	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
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

California Correctional Health Care Services' Response

February 7, 2022

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

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Kern Valley State Prison (KVSP) conducted from July to December 2020. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3557.

Sincerely,

DocuSigned by:
Erin Hoppin
BCF90268393845D...

Erin Hoppin
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Richard Kirkland, Chief Deputy Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Jackie Clark, Deputy Director, Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region III, CCHCS
Regional Deputy Medical Executive, Region III, CCHCS
Regional Nursing Executive, Region III, CCHCS
Chief Executive Officer, KVSP
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

Cycle 6

Medical Inspection Report

for

Kern Valley State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

STATE *of* CALIFORNIA
February 2022

OIG