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UNITED STATES BANKRUPTCY COURT

EASTERN DISTRICT OF CALIFORNIA

In re: OROVILLE HOSPITAL, et al., Debtors and Debtors-in-Possession.	Lead Case No. 25-26876 Jointly Administered With: Case No. 25-26877
☒ Affects All Debtors ☐ Affects Oroville Hospital ☐ Affects OroHealth Corporation: A Nonprofit Healthcare System Debtors and Debtors-in-Possession.	Chapter 11 DCN: PCO-1 Judge: Hon. Christopher D. Jaime [NO HEARING REQUIRED]

THIRD REPORT BY PATIENT CARE OMBUDSMAN

PURSUANT TO 11 U.S.C. §333

Jacob Nathan Rubin, M.D., F.A.C.C., the Patient Care Ombudsman appointed under §333 of the Bankruptcy Code in the above referenced Chapter 11 bankruptcy cases of Oroville Hospital, a California nonprofit public benefit corporation and OroHealth Corporation: A Nonprofit Healthcare System (hereinafter, the "Debtors"), hereby submits his third report to the Court regarding the quality of patient care provided to the Debtors' patients.

Dated: July 9, 2026

By: _____

Patient Care Ombudsman
Jacob Nathan Rubin, M.D., F.A.C.C.

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I. PATIENT CARE OMBUDSMAN'S APPOINTMENT

Oroville Hospital, a California nonprofit public benefit corporation ("Oroville Hospital") and OroHealth Corporation: A Nonprofit Healthcare System ("OroHealth"), hereinafter, the "Debtors," each filed a voluntary petition for relief under Chapter 11 of the Bankruptcy Code on December 8, 2025.

OroHealth, Oroville Hospital, and their affiliated nondebtor entities operate as a California nonprofit health care system in and around Butte County, California, with approximately 133 general acute care beds, an active emergency room, 14 "flex" beds separately authorized by the California Department of Public Health on an annual basis, and 126 skilled nursing facility beds. OroHealth, Oroville Hospital, and their affiliated nondebtor entities also provide 33 specialty services at their 31 clinics (including 10 rural health clinics) in Oroville, Yuba City, and Chico, and provide laboratory services through Valley Clinical Laboratory with 23 outpatient laboratory draw stations in Oroville, Yuba City, Chico, Grass Valley, Orland, and Redding.

Because the Debtors provide care and medical service to patients, this is a "health care business" case as that term is defined in Bankruptcy Code §101(27)(A). Under the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, a patient care ombudsman must be appointed in the bankruptcy case of a "health care business" to ensure that the medical care provided to patients is not declining or being materially compromised during the bankruptcy.

Accordingly, the Court ordered the appointment of a patient care ombudsman pursuant to 11 U.S.C. §333 (a)(1) to monitor, and report to the Court, the quality of patient care provided by the Debtors [Docket No. 290].

Following due diligence and interviews by the United States Trustee ("UST"), Jacob Nathan Rubin, M.D., F.A.C.C. ("Dr. Rubin") was appointed as the Patient Care Ombudsman (the "PCO") in this case, as of January 22, 2026 [Docket No. 317].

Since that time, the PCO has performed the duties described in 11 U.S.C. §333(b) and (c). The PCO performs his duties with the assistance of Timothy Stacy DNP, ACNP-BC.

II. INTRODUCTION

The PCO's *First Report* [Docket No. 570] addressed the initial period of PCO review and concluded that the Debtors' Chapter 11 proceedings had not materially impaired patient care at Oroville Hospital, the affiliated outpatient clinics, or the skilled nursing facility. The First Report nevertheless identified several areas requiring continued monitoring, including emergency department throughput, sepsis performance, stroke imaging timeliness, infection prevention, high-risk medication processes, quality-improvement follow-through, skilled nursing facility performance, hospital-SNF transfer integrity, governance accountability, and medical professional liability insurance continuity.

The PCO's *Second Report* [Docket No. 793] focus remained system performance: whether the hospital and affiliated care settings continue to maintain clinical operations, staffing structures, patient-safety monitoring, regulatory responsiveness, and governance oversight sufficient to protect patients during the bankruptcy process.

This Third Report focuses principally on developments after the Second Report was filed, and incorporates the prior reports where necessary for continuity and then addresses new information produced during the third reporting cycle, including June 2026 document productions, June 2026 meeting materials, email communications, pharmacy and high-risk medication materials, executive and board oversight materials, skilled nursing facility follow-up, emergency department data, infection-prevention and environment-of-care materials, and sale-transition concerns.

The core conclusion remains favorable but guarded. The Debtors' health care operations remain operational. The PCO has not identified evidence that the Chapter 11 proceedings have, to date, materially impaired patient care. Essential clinical services

remain available. Quality oversight structures continue to function. Nevertheless, the hird reporting period identified several high-signal monitoring areas that require continuing attention: emergency department access and boarding, sepsis documentation and care-process reliability, infection-prevention closure discipline, water-management documentation, high-risk medication communication, skilled nursing facility execution reliability, data extraction limitations, Quality Assurance and Performance Improvement analytics, and sale-transition/bondholder actions that could threaten continuity of care.

The most important new patient-care issue is not a routine quality metric. The most important new patient-care issue is the possibility that creditor or bondholder action could attempt to force shutdown, asset liquidation, or diversion of accounts receivable needed for continued operations. Such action would transform a functioning but financially distressed health care system into a direct patient-access threat. The PCO's statutory duty is not to maximize creditor recovery, protect estate distributions, or favor one constituency over another. The PCO's statutory duty is to monitor quality of patient care and represent patient interests. If any proposed financial remedy threatens to close Oroville Hospital, disrupt essential services, destabilize staffing, impair pharmacy and supply-chain access, or remove operating liquidity needed for patient care, the PCO must identify that remedy as a material patient-care risk.

III. EXECUTIVE SUMMARY

The third reporting period confirms that Oroville Hospital remains a critical regional access point for emergency, inpatient, outpatient, procedural, obstetric, post-acute, laboratory, and specialty services. Oroville Hospital serves a medically vulnerable population with limited practical alternatives. Health care access is not fungible in this community. Replacement access is not achieved merely by pointing to a larger hospital somewhere else on a map.

During the third reporting period, Oroville Hospital continued to operate as a critical regional access point for emergency, inpatient, outpatient, procedural, obstetric, post-acute, laboratory, pharmacy, and specialty services. The PCO did not identify current evidence that the Chapter 11 proceedings have caused closure of major service lines or present inability to deliver essential care. The organization also produced substantial additional materials and demonstrated diligence in addressing identified deficiencies, particularly in emergency department throughput, sepsis review, infection-prevention follow-through, high-risk medication controls, skilled nursing facility corrective action, and governance reporting.

The emergency department remains functional but continues to show significant operational pressure. January through May 2026 Left Without Being Seen (LWBS) data showed 608 patients leaving without being seen among 11,084 emergency department visits, or 5.5 percent. The evening and overnight period was the dominant signal, with 70 percent of LWBS events occurring from 4:00 p.m. to 4:00 a.m. and 36 percent occurring from 8:00 p.m. to midnight. A June 6 through June 14, 2026 emergency department throughput extract showed 109 sampled encounters, 54 admissions, and 18 admitted patients boarding at least four hours after the decision to admit. The longest decision-to-departure interval was 2,189 minutes, approximately 36.5 hours.

The Debtors reported that front-end advanced practice provider and scribe coverage from 10:00 a.m. to 10:00 p.m. materially reduced LWBS performance from a prior level reportedly near 20 percent. Oroville also acknowledged that LWBS performance rises when front-end coverage ends at 10:00 p.m. That information is important because it identifies both progress and a remaining operational deficit. The facility appears to have found an intervention that works; the unresolved issue is whether that intervention can be expanded, redesigned, or supported during the evening and overnight failure mode.

Sepsis performance remains a patient-safety and documentation priority. Supplied 2025 quarterly analyses showed Sepsis Early Management Bundle measure pass rates

ranging from 57 percent to 88 percent, with recurring failure modes involving blood cultures, antibiotic timing, septic shock reassessment, fluid documentation, and vasopressor-related documentation. Stroke workflow information was mixed but partly reassuring. Meeting materials described average door-to-computed-tomography time of approximately 11 minutes for stroke patients without exclusions. Door-to-needle time, teleneurology and teleradiology workflow, exclusion criteria, and transfer data remain appropriate monitoring points.

Infection-prevention documentation is extensive and did not show an obvious 2025 National Healthcare Safety Network excess hospital-acquired infection signal in the reviewed standardized infection ratio outputs. The more important weakness is closure discipline: corrective-action ownership, completion dates, escalation pathways, repeat-finding management, and governing-body visibility require stronger documentation. Water-management documentation also requires clarification because one Plan of Correction data collection form reportedly identified first quarter 2026 compliance of 49 percent and stated that the goal was not achieved, while another table reported 98 percent control-measure documentation.

Pharmacy and high-risk medication controls remain operational. The heparin data nonetheless require continued attention because provider-notification compliance reportedly decreased from 100 percent in the fourth quarter of 2025 to 84.2 percent in the first quarter of 2026. High-risk medication safety depends on reliable nursing, pharmacy, provider, electronic-health-record, audit, and education processes. The facility has responded with heparin drip review, bedside registered nurse education, dual-verifying registered nurse education, and workflow support.

The skilled nursing facility remains a central monitoring area. Prior survey and Plan of Correction materials identified resident-rights, staffing and call-light, Minimum Data Set, abuse and neglect, dialysis monitoring, psychotropic medication consent, dietary, Payroll-Based Journal reporting, environmental, and equipment concerns. Survey

outcomes appear improved and the organization appears diligent in working through deficiencies. The remaining patient-care issue is durable proof that corrective actions continue to work after the survey cycle ends.

Data integrity remains a governance issue. Oroville reported continued inability to reliably extract certain emergency department throughput data from the electronic health record and therefore used handwritten tracking sheets for approximately 12 days, producing approximately 900 sheets and a random sample of 109 encounters. That work shows commitment. It also shows why routine quality improvement cannot depend on extraordinary manual reconstruction. Board and executive oversight remain active, but the next step is closed-loop governance with accountable owners, due dates, audit methods, numerators, denominators, escalation criteria, and Board visibility.

Creditor or bondholder action that would shut down operations, strip accounts receivable needed for operations, or force asset liquidation would present a catastrophic patient-care risk. Based on information reviewed to date, the PCO does not identify a present basis for directed intervention into current bedside operations. The material patient-care observation is different: any proposed creditor remedy affecting operational liquidity, service continuity, staffing, pharmacy access, malpractice coverage, or patient transfers would create patient-care risk if implemented without a patient-care impact analysis and continuity plan.

IV. METHODOLOGY AND SOURCES REVIEWED DURING THIRD REPORTING PERIOD

The Third Report uses the same systems-based methodology applied in the First and Second Reports. The PCO reviewed whether patient care is safe, effective, reasonably continuous, and supported by functioning quality systems. The PCO did not conduct a comprehensive regulatory survey, accreditation audit, malpractice adjudication, or exhaustive chart review. The PCO's role remains focused on whether the bankruptcy

process or sale-transition process is causing or threatening material compromise of patient care.

Sources reviewed during the third reporting period included the First Report and Second Report; June 2026 meeting planning materials focused on emergency department operations, infection prevention, environment of care, Continuous Quality Improvement, Quality Assurance and Performance Improvement, executive leadership, and Board visibility; a June 17, 2026 supplemental document production described as 146 files, including 113 Portable Document Format files, 32 Excel workbooks, and one HyperText Markup Language file; June 17, 2026 meeting notes and addendum materials addressing Left Without Being Seen, emergency department boarding, sepsis, stroke, infection prevention, environment of care, data integrity, and Quality Assurance and Performance Improvement expectations; skilled nursing facility survey and Plan of Correction materials addressing federal deficiency tags, resident rights, staffing, Minimum Data Set, abuse and neglect, dialysis monitoring, psychotropic medication consent, dietary, Payroll-Based Journal reporting, equipment, environment of care, and grievances; pharmacy and executive leadership/Board oversight materials uploaded to the PCO folder on June 22 through June 23, 2026, including high-risk medication and heparin-notification information; email traffic and ShareFile activity notices relevant to the Third Report workstreams; and public statutory sources, including 11 United States Code section 333, the Bankruptcy Abuse Prevention and Consumer Protection Act Title XI, and related health care bankruptcy provisions.

Certain materials were supplied as scanned documents, raw logs, Excel workbooks, dashboard outputs, or meeting summaries. The PCO treated those materials as monitoring evidence and assessed both substantive patient-care signals and documentation reliability. Several data sets require follow-up because incomplete extraction, inconsistent fields, or conflicting summary statements limit definitive interpretation.

V. COMMUNITY DEPENDENCY AND CONSEQUENCES OF A CREDITOR-DRIVEN CLOSURE

The PCO has repeatedly emphasized that Oroville Hospital serves as a regional health care access point for a medically vulnerable population. Community dependency is not merely contextual. Community dependency is a patient-care fact. The local health care system includes emergency services, acute inpatient beds, intensive care unit services, surgical and procedural services, diagnostic imaging, obstetrics, outpatient clinics, specialty care, laboratory services, pharmacy access, and post-acute services through the skilled nursing facility.

The practical consequence of closure would be severe. Health system participants described alternative hospital access as approximately one hour away in many circumstances, with clinic, provider, and specialty access often farther or more difficult. The PCO has not treated that statement as a precise ambulance-transport calculation for every address in the service area. The PCO has treated the statement as an accurate clinical warning: Oroville patients do not have a reasonable, equivalent, immediately substitutable access to the full range of services currently provided by the Debtors.

A creditor-driven shutdown or accounts-receivable sweep would create predictable patient-care harms. Emergency medical services would face longer transports, more frequent diversion, and higher risk for time-sensitive conditions such as sepsis, stroke, acute coronary syndromes, respiratory failure, trauma, obstetric emergencies, and surgical emergencies. Patients dependent on outpatient clinics would lose primary care, specialty care, wound care, oncology and hematology access, pulmonary care, endocrinology, neurology, gastroenterology, orthopedic care, pediatric care, and post-discharge follow-up pathways. Skilled nursing facility residents would lose an integrated acute-care escalation pathway and would face increased transfer complexity during clinical deterioration. Surrounding hospitals would absorb volume without necessarily having immediately available beds, staff, specialists, transport capacity, or clinic access. Medication access

through pharmacy operations and the 340B Drug Pricing Program could be disrupted for patients with chronic illness. Medical staff, nursing staff, and ancillary staff could rapidly disperse, making any later restart more difficult even if a financial compromise were reached. Community confidence would deteriorate, and delayed care would increase as patients defer evaluation rather than travel farther for routine, urgent, or specialty care.

The PCO therefore views continuity of Oroville operations as a patient-safety issue. A health care business can appear financially distressed on paper and still remain clinically essential. Oroville Hospital is such a case. The record reviewed by the PCO does not justify the conclusion that current patient care requires shutdown. The record supports the opposite conclusion: current operations remain necessary for the community and must be protected while restructuring and sale issues proceed.

VI. MATERIAL DEVELOPMENTS SINCE SECOND REPORT

The third reporting period involved several material developments and workstreams. The June 2026 Third Report document production was substantial and included emergency department, sepsis, stroke, infection prevention, environment-of-care, National Healthcare Safety Network, water-management, sterile-processing, and related files. The production provided meaningful patient-care information and also demonstrated the need for clearer capsule summaries, data dictionaries, accountable owners, and closure tracking so the key patient-care signal is not buried in a large document production.

The June 17 emergency department, infection-prevention, and environment-of-care meeting addressed LWBS performance, boarding, triage advanced practice provider coverage, nighttime throughput, sepsis, stroke, infection prevention, environment of care, floor remediation, and data-extraction limitations. The meeting demonstrated leadership engagement and identified practical operational levers that the organization is already working to convert into Continuous Quality Improvement and Quality Assurance and Performance Improvement processes.

The emergency department throughput extract for June 6 through June 14 showed 54 admissions among 109 sampled encounters and 18 admitted patients boarding at least four hours after the decision to admit. The emergency department remains functional, but the throughput pressure is clinically material and requires sustained ownership. Sepsis review materials showed recurrent Sepsis Early Management Bundle measure failure modes, while the facility described monthly or bimonthly review, provider counseling, electronic-health-record alerts, blood-culture order support, reminders, empiric-antibiotic attention, and trialed waiting-room antibiotic workflow for selected patients without intravenous access.

Infection-prevention and environment-of-care materials included extensive logs and surveillance outputs. The PCO did not identify an obvious collapse in infection control based on those materials, but the corrective-action closure process requires stronger evidence. Pharmacy materials uploaded June 22 through June 23 reflected continued pharmacy and high-risk medication monitoring. Pharmacy remains operational, while high-risk medication communication, especially heparin provider notification, remains an audit and education priority.

Skilled nursing facility survey and Plan of Correction follow-up materials addressed resident rights, Minimum Data Set, staffing, abuse and neglect, dialysis monitoring, psychotropic medication oversight, dietary, Payroll-Based Journal reporting, environment, and equipment. The skilled nursing facility appears to be improving and the organization appears diligent in working through the deficiencies. The remaining issue is durability: survey completion is a checkpoint, not the finish line.

VII. EMERGENCY DEPARTMENT OPERATIONS: ACCESS, LEFT WITHOUT BEING SEEN, BOARDING, AND THROUGHPUT

The emergency department remains the clearest operational signal in the third reporting period. Oroville Hospital's emergency department remains open and functional.

The PCO did not identify evidence that the emergency department has become unavailable because of Chapter 11. However, emergency department access metrics show real pressure, a metric of consequence, because the emergency department is the principal access point for a medically vulnerable community.

A. LWBS Performance

The June 2026 document production identified 608 LWBS patients among 11,084 emergency department visits from January through May 2026, resulting in a LWBS rate of 5.5 percent. Meeting materials reported May 2026 LWBS at 5.6 percent, with April and another recent month reported at 4.9 percent. The facility clarified that 36 percent refers to the share of LWBS events occurring between 8:00 p.m. and midnight, not 36 percent of all emergency department patients leaving.

The temporal pattern is the most important finding. Seventy percent of LWBS events occurred from 4:00 p.m. to 4:00 a.m. Thirty-six percent occurred from 8:00 p.m. to midnight. That pattern indicates a front-end capacity, staffing, triage, throughput, and nighttime-flow problem rather than a uniform 24-hour emergency department failure.

B. Front-End Advanced Practice Provider and Scribe Coverage

Oroville reported that placing an advanced practice provider and scribe in the triage/front-end area from 10:00 a.m. to 10:00 p.m. significantly reduced LWBS from a prior level reportedly near 20 percent. The facility acknowledged that LWBS increases after the front-end coverage ends at 10:00 p.m. and that continuous front-end coverage would likely be needed to push LWBS toward a 2 percent goal. The PCO views this information as important because the intervention appears to work. The unresolved issue is whether coverage can be expanded, supported, or redesigned to address the evening and overnight failure mode.

C. Boarding and Throughput

A June 6 through June 14, 2026 emergency department throughput extract included 109 encounters, 54 admissions, and 55 discharges. Eighteen admitted patients boarded at

least four hours after the decision to admit. The longest decision-to-departure interval was 2,189 minutes, approximately 36.5 hours. That outlier is clinically important. Such a delay can reduce emergency department capacity, increase crowding, delay care for new arrivals, and contribute to LWBS risk.

Emergency Department Metric	Finding	Interpretation
Left Without Being Seen, January through May 2026	608 LWBS among 11,084 emergency department visits, or 5.5 percent.	Access pressure remains material.
LWBS time pattern	70 percent from 4:00 p.m. to 4:00 a.m.; 36 percent from 8:00 p.m. to midnight.	Evening/overnight front-end and throughput signal.
June 6 through June 14 throughput sample	109 encounters; 54 admissions; 55 discharges.	Sample supports focused throughput review.
Boarding after admit decision	18 admitted patients boarded at least 4 hours.	Inpatient capacity and process reliability require ownership.
Longest decision-to-departure	2,189 minutes, approximately 36.5 hours.	High-risk outlier requiring case-level review.
Data extraction method	Handwritten sheets for approximately 12 days; random sample of 109 encounters.	Electronic health record extraction limitation impairs Quality Assurance and Performance Improvement reliability.

D. Emergency Department Interpretation

The PCO does not conclude that emergency department metrics demonstrate bankruptcy-caused impairment. Emergency department crowding and throughput problems are common in community hospitals. However, Oroville's emergency department metrics are too important to treat as background noise. The emergency department is the patient-access front door. A stable bankruptcy process cannot be called safe if emergency department access deteriorates while dashboards merely describe the deterioration. The hospital needs to convert emergency department data into an accountable solution.

The emergency department workstream remains appropriate for monthly monitoring and includes LWBS performance by hour and day, door-to-provider time, door-to-disposition time, decision-to-admit time, decision-to-departure time, discharge delay, admitted-patient boarding hours, staffing gaps, inpatient bed constraints, environmental-services delay, nursing capacity, hospitalist acceptance timing, level-of-care assignment, radiology read turnaround, and case-level outlier review. Oroville's

development of manual tracking despite electronic-health-record limitations reflects diligence, but durable improvement requires a repeatable data process.

VIII. SEPSIS, STROKE, AND TIME-SENSITIVE EMERGENCY CARE

A. Sepsis

Sepsis remains a major patient-safety domain because sepsis care is time-sensitive and documentation-sensitive. Supplied 2025 sepsis analyses identified recurring Sepsis Early Management Bundle measure failure modes, including blood cultures not obtained before antibiotics or not obtained in the required window, delayed or absent antibiotics, incomplete septic shock reassessment documentation, incomplete fluid compliance, and one vasopressor-related failure. Supplied quarterly pass rates ranged from 57 percent to 88 percent.

During the June 17 meeting, Oroville described monthly or bimonthly review of Sepsis Early Management Bundle measure failures, individual provider counseling, electronic health record/dashboard alerts, auto-firing blood culture orders, flyers and reminders, low threshold for empiric antibiotics, and trialing intramuscular ceftriaxone for waiting-room patients without intravenous access. The facility does not currently use an overhead Code Sepsis process. Oroville described historical improvement from approximately 30 percent to the 60 percent to 70 percent range, with discussion of a 77 percent to 80 percent benchmark and a facility statement that the hospital had reached 75 percent in at least one period.

The PCO interprets this information as evidence of an active sepsis improvement program. The program still requires more precise analytics. Each failed Sepsis Early Management Bundle measure case is best classified as documentation failure, clinical delay, laboratory delay, antibiotic availability issue, provider recognition delay, nursing workflow issue, electronic health record trigger failure, intravenous access issue, triage/waiting-room delay, or exclusion/abstraction issue.

B. Stroke

Stroke workflow remains a key time-sensitive domain. Meeting materials reported average door-to-computed-tomography time of approximately 11 minutes for stroke patients without exclusions, which is favorable and indicates imaging availability when stroke workflows are activated. The facility also reported thrombolytic use across first quarter of 2025 through first quarter of 2026. Oroville reported that emergency department physicians generally make thrombolytic decisions without required neurology consultation because prior teleneurology involvement reportedly delayed tissue plasminogen activator administration.

The PCO does not identify a present stroke-service failure based on information reviewed. Continued monitoring focuses on door-to-needle time, exclusion criteria, radiology read timing, teleneurology/teleradiology decision points, thrombolytic case list, hemorrhagic complication review, transfer/interventional stroke data, and Continuous Quality Improvement review of outliers.

IX. IINFECTION PREVENTION, ENVIRONMENT OF CARE, AND WATER MANAGEMENT

The infection-prevention and environment-of-care production was extensive. Materials included environment-of-care rounds, National Healthcare Safety Network standardized infection ratio outputs, water-management materials, sterile processing and cleaning logs, ice machine and eyewash logs, multidrug-resistant organism tracking, surgical site infection tracking, and related surveillance materials. The existence of documentation is positive.

The 2025 National Healthcare Safety Network standardized infection ratio outputs supplied for central line-associated bloodstream infection, catheter-associated urinary tract infection, Clostridioides difficile infection, methicillin-resistant Staphylococcus aureus bloodstream infection, ventilator-associated event, and surgical site infection measures did

not show an obvious excess hospital-acquired infection signal based on the summarized review. Several standardized infection ratios were not calculated because predicted events were below 1.0. That limitation is common in smaller facilities and is not overread in this report. The absence of a clear 2025 National Healthcare Safety Network excess signal does not close 2026 infection-prevention, environment-of-care, or water-management corrective-action concerns.

The most important weakness identified in the infection-prevention and environment-of-care workstream is closure discipline. The facility response reportedly stated that infection-prevention findings are not currently tied to corrective-action owners and completion dates, and that repeat findings are escalated informally. Informal escalation is not a durable quality system. A formal environment-of-care and infection-prevention corrective-action tracker would better demonstrate owner, due date, compliance metric, audit denominator, result, failure escalation, and committee/Board reporting.

Water-management documentation requires specific reconciliation. The water-management Plan of Correction data collection form reportedly identified inconsistent documentation of water-system pathogen prevention activities, stated first quarter of 2026 compliance was 49 percent, and stated the goal was not achieved. The same document reportedly contained a table reporting 98 percent control-measure documentation. The PCO cannot treat both numbers as simultaneously explanatory without reconciliation. The facility needs to identify which denominator, which control measures, which locations, and which audit period produced each number.

During the June 17 meeting, Oroville reported that a resurvey occurred approximately two weeks earlier, that the facility expected no infection-control deficiencies, and that the CMS-2567 (federal “Statement of Deficiencies and Plan of Correction”) had not yet been received. Oroville described some floors as appearing dirty largely because of strip-and-wax needs and described a room-by-room or floor-by-floor remediation plan. The organization’s response reflects active remediation. The remaining

patient-care issue is verification through the final CMS-2567, the remediation schedule, and proof of completion.

X. PHARMACY, HIGH-RISK MEDICATION CONTROLS, AND 340B DRUG PRICING PROGRAM ACCESS

The First Report found pharmacy operations functional and did not identify bankruptcy-related medication access failure. The Third Report continues that conclusion based on information reviewed to date. Pharmacy remains a critical monitoring area because pharmacy operations are sensitive to vendor confidence, purchasing liquidity, formulary substitutions, controlled substances, high-risk medications, 340B Drug Pricing Program access, and sale-transition planning.

The June 22 through June 23 ShareFile activity reflected uploads to the PCO Pharmacy Inquiry folder. Pharmacy and executive leadership/Board oversight materials reviewed during the third reporting period included heparin provider-notification materials and Continuous Quality Improvement and Board oversight materials. High-risk medication controls are clinically important because failure to notify providers of abnormal therapeutic measurements, platelet changes, bleeding, neurologic changes, or repeat out-of-range values can produce preventable harm.

The heparin data are mixed. Fourth quarter of 2025 heparin provider-notification compliance reportedly was 100 percent. First quarter of 2026 heparin provider-notification compliance reportedly decreased to 84.2 percent. Fourth quarter of 2025 reportedly included 53 heparin drips, with 36 meeting study criteria. First quarter of 2026 reportedly included 77 heparin drips, with 76 meeting study criteria. Identified failure modes included nursing failure to follow heparin nursing treatment protocol when partial thromboplastin time values were out of range, repeat out-of-range partial thromboplastin time draws without re-notification because prior notification had occurred and values were trending in the intended direction, and provider notification/documentation gaps in Clinicomp.

The facility addressed noncompliance through frequent heparin drip review, bedside registered nurse education, dual-verifying registered nurse education, and workflow support. A Heparin Advisor suspend workflow update became effective in May 2026. These actions are appropriate and reflect active improvement work. Continued audit remains important because a policy that depends on bedside memory under workload pressure is not enough. High-risk medication safety requires electronic-health-record support, nursing workflow clarity, pharmacy oversight, provider response expectations, audit feedback, and Continuous Quality Improvement and Board visibility.

The PCO also emphasizes the importance of 340B Drug Pricing Program and outpatient pharmacy continuity. Oroville's outpatient and vulnerable patient populations depend on medication affordability and continuity. Any sale-transition, vendor disruption, or accounts receivable sweep that destabilizes pharmacy purchasing or 340B Drug Pricing Program operations would directly affect patient care.

XI. SKILLED NURSING FACILITY AND POST-ACUTE CENTER FOLLOW-UP

The skilled nursing facility remains one of the most important patient-care domains because skilled nursing facility residents are medically vulnerable, often frail, cognitively impaired, mobility-limited, nutritionally vulnerable, and dependent on staff for safety, medication administration, hygiene, diet texture, dialysis coordination, and escalation of care. The PCO continues to treat skilled nursing facility issues as direct patient-care issues.

The Second Report described a reported Centers for Medicare and Medicaid Services certification survey result with eleven deficiencies and identified the need to review final survey documentation. Subsequent review materials identified a discrepancy between references to eleven deficiencies and Plan of Correction materials showing ten federal deficiency tags. The identified federal deficiency tags included F812, F851, F908, F584, F636, F638, F725, F600, F698, and F757. The discrepancy requires reconciliation

and explanation of whether any cited item was removed, combined, omitted, or counted differently.

Skilled nursing facility Issue / federal deficiency tag Theme	Patient-Care Significance	PCO Follow-Up Priority
F600 abuse/neglect prevention	Resident protection is a core safety function. Allegations and risks require prompt protection, investigation, documentation, and Quality Assurance and Performance Improvement review.	High priority. Verify investigation process, training, resident protection steps, and Quality Assurance and Performance Improvement closure.
F725 staffing/call-light response	Staffing and response reliability affect falls, toileting, pain, respiratory distress, skin care, dignity, and escalation.	High priority. Review staffing by shift, call-light response, escalation, and audit evidence.
F636/F638 Minimum Data Set timeliness	Minimum Data Set timeliness affects care planning, quality measures, reimbursement accuracy, and resident-specific interventions.	High priority. Review Minimum Data Set calendar, overdue dashboard, backup coverage, and weekly Assessment Reference Date process.
F698 dialysis monitoring	Dialysis access and post-dialysis status monitoring affect bleeding, infection, hypotension, volume status, and hospital transfer risk.	High priority. Review dialysis communication forms, access checks, abnormal findings, and provider escalation.
F757 psychotropic medication consent/oversight	Psychotropics create fall, sedation, delirium, behavior, and resident-rights risks.	High priority. Review consent, indication, monitoring, gradual dose reduction where appropriate, and pharmacist review.
F812 food safety/dietary	Food temperature, texture, cooling logs, sanitation, and recipe compliance affect infection risk, nutrition, aspiration risk, and dignity.	Moderate-high priority. Review tray-line logs, IDDSI/pureed controls, sanitation, and corrective-action audits.
F851 Payroll-Based Journal reporting	Payroll-Based Journal accuracy affects staffing transparency and regulatory reliability.	Moderate priority. Reconcile payroll/staffing data with submitted Payroll-Based Journal data.
F908 equipment/environment	Equipment and environmental integrity affect safety, infection prevention, and daily care reliability.	Moderate priority. Verify repairs, replacement, and environmental rounds.
F584 dignity, environment, belongings, grievances	Resident rights and dignity are patient-care issues, not paperwork.	Moderate-high priority. Review grievance log, closure evidence, resident communication, and belongings process.

The PCO concludes that the skilled nursing facility is safe and that bankruptcy has caused no systemic resident-care collapse. The PCO does concludes that the skilled nursing facility risk profile is execution-dependent. Passing a survey or filing a Plan of Correction is not the end of quality oversight. Survey completion is a checkpoint. Durable compliance requires proof that the process still works after the survey team leaves.

XII. HOSPITAL-SKILLED NURSING FACILITY TRANSITION INTEGRITY AND READMISSION REVIEW

Hospital-Skilled Nursing Facility transitions remain a patient-safety junction. Residents transferred from the skilled nursing facility to the hospital often have acute dyspnea, altered mental status, infection, falls, chest pain, abnormal labs, wounds, dialysis complications, medication effects, or worsening chronic illness. Some transfers are necessary and appropriate. Some transfers may be preventable. Some transfers cannot be classified because documentation is incomplete.

The PCO previously identified transfer-log data limitations. The third reporting period reinforces the same concern. A usable transfer log answers basic questions: why the resident transferred, when clinical change was recognized, whether nursing assessment occurred, when the provider was notified, whether family or representative notification occurred, whether transfer/discharge and bed-hold notices were completed, what hospital disposition occurred, whether the resident returned, whether the transfer was potentially preventable, and what Quality Assurance and Performance Improvement action resulted.

Joint hospital-skilled nursing facility review of selected transfers remains an important patient-care monitoring process, especially for dyspnea, pneumonia, sepsis, heart failure, altered mental status, falls, abnormal labs, dialysis concerns, and rapid return-to-hospital cases. The purpose is not to criticize clinically appropriate transfers. The purpose is to identify whether earlier recognition, provider notification, respiratory protocols, infection protocols, medication review, dialysis access monitoring, or urgent treatment access could reduce avoidable transfers.

XIII. DATA INTEGRITY, QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT ANALYTICS, AND CLOSED-LOOP GOVERNANCE

Data integrity is a patient-safety issue. During the third reporting period, Oroville reported continued inability to reliably extract needed emergency department throughput

data from the electronic health record. Oroville therefore used handwritten tracking sheets for approximately 12 days, reportedly generated approximately 900 sheets, and entered a random sample of 109 encounters into a throughput spreadsheet. That effort demonstrates commitment. That effort also demonstrates a system vulnerability.

Quality improvement cannot depend on manual reconstruction every time leadership, the Patient Care Ombudsman, a regulator, or the Board asks a question. The hospital needs structured, repeatable data for emergency department throughput, Left Without Being Seen, boarding, sepsis failures, stroke outliers, skilled nursing facility transfers, readmissions, heparin notifications, infection-prevention corrective actions, water-management controls, and survey Plan of Correction audits.

Future data productions are most useful when each production includes a one-paragraph capsule summary explaining what was reviewed, what is normal, what is abnormal, what improved, what remains unresolved, who owns an accountable solution, what action has been assigned, and what evidence verifies completion. Raw data remains important. Raw data must not bury the key patient-care signal at the back of a large document production.

Closed-loop governance remains the central maturity issue. The Board and executive leadership need actionable dashboards with owners, thresholds, audit results, noncompliance response, and deadlines. Meeting minutes are most useful when they identify the patient-care issue, responsible owner, action item, due date, result, and escalation plan. Quality systems fail when every metric is "being monitored" but no person owns an accountable solution.

Metric / Issue	Operational Owner	Executive / Board Oversight
Emergency department Left Without Being Seen, emergency department length of stay, boarding	Emergency Department leadership, nursing leadership, hospitalist/inpatient flow leadership, case management	chief medical officer, chief nursing officer, chief operating officer, Board Quality Committee
Sepsis Early Management Bundle measure sepsis	Emergency Department, hospitalists/intensivists, nursing, laboratory, pharmacy, quality	chief medical officer, chief nursing officer, Quality Committee
Stroke imaging/door-to-needle	Emergency Department, radiology, registration, nursing, stroke process owner	chief medical officer, chief operating officer, Quality Committee
Heparin/high-risk medication	Nursing, pharmacy, medical staff,	chief nursing officer, chief medical

Metric / Issue	Operational Owner	Executive / Board Oversight
communication	quality	officer, Continuous Quality Improvement Executive Committee
Infection prevention, environment, and water	Infection Prevention, facilities, environmental services, sterile processing, nursing	chief nursing officer, chief operating officer, Board Quality Committee
Skilled nursing facility resident rights, staffing, Minimum Data Set, transfers	Skilled nursing facility Administrator, Director of Nursing, Minimum Data Set Coordinator, Social Services	Executive leadership and Board Quality Committee
Sale-transition patient-care risk	chief executive officer/chief operating officer/chief financial officer, chief medical officer, chief nursing officer, legal, transition team	Board, Court-facing sale process, PCO notification

XIV. RISK ASSESSMENT

The PCO assigns the following risk assessment based on information reviewed during the third reporting period:

Domain	Risk Level	Rationale	Monitoring Focus
Current hospital operations	Moderate / Stable	Essential services remain operational; no current evidence of bankruptcy-caused collapse.	Continue monitoring staffing, supplies, pharmacy, service lines, and malpractice coverage.
Emergency department access/throughput	High	LWBS 5.5 percent January through May 2026; 70 percent LWBS between 4:00 p.m. and 4:00 a.m.; boarding outlier 36.5 hours.	Monthly dashboard with case-level outliers, owners, and action plan.
Sepsis	Moderate-high	Sepsis Early Management Bundle measure pass rates 57 percent to 88 percent; recurring blood culture, antibiotic, reassessment, and fluid documentation failures.	Monthly/bimonthly case review separating documentation versus clinical delays.
Stroke	Moderate	Door-to-computed tomography reported approximately 11 minutes; door-to-needle and transfer details require review.	Door-to-needle, teleneurology/teleradiology, thrombolytic, and transfer data.
Infection prevention, environment, and water	Moderate-high	Extensive documentation; closure discipline and water-management discrepancy unresolved.	Owner/date/action tracker, audit evidence, final 2567 review.
Pharmacy/high-risk medications	Moderate	Pharmacy operational; heparin compliance declined to 84.2 percent in first quarter of 2026.	Heparin audits, failure-mode education, electronic health record workflow verification.
Skilled nursing facility	Moderate-high	Survey improvement reported, but federal	Quality Assurance and Performance Improvement

Domain	Risk Level	Rationale	Monitoring Focus
		deficiency tags involve direct and indirect resident-care risk.	proof of sustained compliance, federal deficiency tag reconciliation, transfer-log review.
Data integrity/Quality Assurance and Performance Improvement analytics	High	electronic health record extraction limitations required manual emergency department data reconstruction.	Structured data plan and capsule summaries for all major productions.
Governance/Board oversight	Moderate	Governance active; closed-loop evidence needs strengthening.	Board packets showing owners, actions, due dates, audit results, and escalation.

Overall current operational risk is manageable with continued monitoring. Closure risk is not manageable as a routine business decision. Closure risk is catastrophic because closure risk affects access to life-sustaining care for an entire community.

XV. FORWARD-LOOKING MONITORING OBSERVATIONS

A. Emergency Department

Emergency department monitoring remains focused on LWBS performance by month, hour, shift, day of week, and staffing model. The front-end advanced practice provider and scribe model appears to have improved access during covered hours, while the evening and overnight pattern identifies the remaining deficit. Emergency department length of stay, decision-to-admit to departure, admitted boarding hours, and outliers over four, eight, twelve, and twenty-four hours remain important operational indicators. Inpatient bed constraints, level-of-care assignment delays, radiology read delays, nursing bed closures, and discharge-flow barriers remain accountable solution areas.

B. Sepsis and Stroke

Sepsis monitoring remains focused on classifying each Sepsis Early Management Bundle measure failure as a documentation failure, blood-culture timing failure, antibiotic delay, intravenous-access or waiting-room barrier, reassessment documentation failure, fluid-compliance issue, vasopressor documentation issue, or clinical-recognition delay. The operational observation is that an overhead Code Sepsis process or equivalent escalation pathway may reduce recognition and timing failures if case review shows

repeated delay patterns. Stroke monitoring remains focused on door-to-needle times, thrombolytic case lists, exclusion criteria, teleneurology and teleradiology workflow, and transfer or interventional stroke data.

C. Infection Prevention, Environment of Care, and Water Management

Infection prevention and environment-of-care monitoring remains focused on the final 2567 when received, any infection-control or environment-of-care deficiencies, and a corrective-action tracker that identifies owner, due date, action, audit denominator, compliance result, repeat finding, escalation, and closure verification. Water-management documentation requires reconciliation between the reported 49 percent first-quarter compliance figure and the reported 98 percent control-measure documentation figure. Floor remediation and related environmental work remain most useful when supported by a room-by-room or floor-by-floor schedule and completion verification.

D. Pharmacy and High-Risk Medication

Pharmacy and high-risk medication monitoring remains focused on heparin provider-notification audits, compliance reporting to Continuous Quality Improvement and Board quality structures, implementation of the Heparin Advisor suspend workflow update, and whether the update reduces repeat out-of-range notification failures. High-risk medication failure modes remain best analyzed by nursing workflow, provider notification, electronic-health-record documentation, pharmacy review, and education response. Pharmacy purchasing, 340B Drug Pricing Program operations, and vendor relationships remain patient-care issues during any sale or cash-collateral dispute.

E. Skilled Nursing Facility and Hospital-Skilled Nursing Facility Transitions

Skilled nursing facility monitoring remains focused on reconciling the ten-versus-eleven deficiency discrepancy, identifying final federal deficiency tags, confirming scope and severity, and reviewing Plan of Correction completion evidence. The resident-care significance is highest for F600, F725, F636/F638, F698, and F757 because those areas carry direct or high-likelihood resident-care risk. Transfer-log completeness remains

central: date and time, reason, assessment, provider notification, family or representative notice, transfer/discharge notice, bed-hold notice, hospital disposition, preventability review, and Quality Assurance and Performance Improvement action. Joint review remains most useful for transfers involving dyspnea, infection, pneumonia, congestive heart failure, altered mental status, falls, abnormal labs, dialysis concerns, and rapid readmission.

F. Data Integrity and Governance

Data integrity and governance monitoring remains focused on structured, repeatable data extraction for emergency department throughput, sepsis, stroke, skilled nursing facility transfers, readmissions, heparin notification, infection prevention, water management, and survey corrective actions. Future productions are more useful when a capsule summary identifies what is normal, abnormal, improved, unresolved, assigned, and verified. Board and Continuous Quality Improvement packet excerpts remain important because they show issue owners, action items, due dates, audit results, noncompliance response, and escalation.

XVI. CONCLUSION

Based on information reviewed during the third reporting period, the PCO has not identified current evidence that the Debtors' Chapter 11 proceedings have materially impaired patient care at Oroville Hospital, affiliated clinics, or the skilled nursing facility. The hospital remains operational. Essential services continue. Quality systems remain active. Leadership is engaged in responding to identified patient-care pressure points.

The favorable conclusion does not eliminate ongoing monitoring obligations. Emergency department access and boarding require sustained operational intervention. Sepsis performance requires sharper case-level analytics. Stroke metrics require continued verification. Infection prevention and environment-of-care issues require formal closure discipline. Water-management documentation requires reconciliation. Heparin and high-risk medication controls require continued audit. The skilled nursing facility requires

durable compliance proof. Data integrity requires improvement. Governance requires closed-loop evidence, not passive dashboards. The organization's efforts and responsiveness are evident; the remaining issue is whether the improvements are hardwired and sustained.

The PCO will continue monitoring, with particular attention to any transaction or creditor action affecting operational liquidity or service continuity and to advance notice before any action that could materially compromise patient care. If patient care begins declining significantly or becomes materially compromised, section 333 requires immediate report or motion to the Court. The PCO will continue to perform that function.

Source / Workstream	Materials Reviewed / Considered	Report Use
First Report	Baseline PCO report addressing initial operations, care continuity, emergency department, skilled nursing facility, pharmacy, quality systems, governance, and malpractice coverage.	Baseline for current stability and continuing monitoring domains.
Second Report	Follow-up report addressing sale process, skilled nursing facility certification survey, transfer logs, emergency department metrics, data integrity, and third-report framework.	Continuity for third reporting period and unresolved monitoring plan.
June 17 document production	Production summarized as 146 files: 113 Portable Document Format files, 32 Excel workbooks, and 1 HyperText Markup Language file.	Basis for emergency department, sepsis, stroke, infection prevention/environment of care, water, National Healthcare Safety Network, and data-integrity sections.
June 17 meeting notes addendum	Meeting notes addressing Left Without Being Seen, front-end advanced practice provider coverage, emergency department boarding, sepsis, stroke, infection prevention/environment of care, floor remediation, and data extraction limitations.	Basis for operational findings and monitoring observations.
June 17 meeting problem sheet	PCO meeting focus document addressing emergency department operations and infection prevention/environment of care.	Used to structure third-report questions and follow-up criteria.
Skilled nursing facility survey / Plan of Correction	federal deficiency tags and corrective-action materials concerning resident rights, staffing, Minimum Data Set, abuse/neglect, dialysis, psychotropics, dietary, Payroll-Based Journal, environment, and equipment.	Basis for skilled nursing facility section and monitoring observations.
Pharmacy / Board oversight	ShareFile activity and pharmacy	Basis for pharmacy and high-risk

Source / Workstream	Materials Reviewed / Considered	Report Use
production	inquiry materials uploaded June 22 through June 23, including heparin high-risk medication materials and Continuous Quality Improvement and Board oversight themes.	medication section.
Email and ShareFile review	Post-Second Report communications, document notices, meeting scheduling/status updates, and court filing notices.	Used to identify relevant workstreams and timing.
Statutory sources	11 United States Code section 333; Bankruptcy Abuse Prevention and Consumer Protection Act Title XI; health care business definition; patient-transfer duties for closing health care businesses.	Basis for statutory framework and patient-care analysis of closure/bondholder risk.

Dated: July 9, 2026

By: _____

Patient Care Ombudsman
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