Disability Rights California

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Joint Oversight Hearing
Assembly Committee on Aging and Long-Term Care &
Assembly Committee on Health

Department of Public Health Oversight of Long-Term Care Facilities

January 21, 2014

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Thank you for the opportunity to address your Committee today regarding the responsiveness of the Department of Public Health (Department) to consumer complaints about long-term care facilities and professionals certified by the Department.

As you know, Disability Rights California is the agency mandated by federal law to protect and advocate for Californians with disabilities. One of our most critical functions is the investigation of abuse and neglect. Under federal and state law, Disability Rights California has the authority to investigate any incident of abuse or neglect of any person with a disability if the incident is reported to Disability Rights California or if Disability Rights California determines there is probable cause to believe the abuse or neglect has occurred. We have conducted over 200 investigations into alleged abuse or neglect of people with disabilities occurring in long-term care facilities and currently we have 12 open investigations.

In addition to elders, long-term care facilities serve a large population of non-elderly adults with disabilities. This includes adults with developmental disabilities residing in intermediate care facilities (ICFs), such as state

developmental centers, and adults with significant physical impairments or mental health disabilities residing in specialized skilled nursing facilities.

Delays in the Department Completing Abuse Investigations

Disability Rights California's case investigations and monitoring of Department citations have documented very significant delays in the Department completing investigations and issuing citations in cases involving grave and/or dangerous practices that have resulted in resident injury and death. In fact, it is the exception rather than the rule that citations are issued within a few months of the incident. Often years lapse before the Department requires that the facility take appropriate corrective action. This is most common in cases that have caused serious injury, disability, or death (i.e. Class A or AA citations). Such lengthy delays leave other vulnerable residents at risk for similar incidents of abuse or neglect during the intervening time period.

In October 2011, Disability Rights California advised the Department about our concerns regarding delays in investigation completion. Disability Rights California provided examples of over a dozen serious incidents for which years lapsed between the incident's occurrence and the issuance of the citation. At one facility, two patients died within a year and a half of each other because staff failed to respond when the patient became disconnected from the ventilator. Had the Department promptly ordered the facility to take corrective action following the first death, the second death might have been prevented. Other incidents included a patient[1] rape by a Certified Nursing Assistant (CNA) (3 years, 10 months lapsed between incident and citation), a patient death from the facility's failure to treat gapping pressure ulcer[2] (3 years, 5.5 months), and the failure of facility staff to recognize that a patient broke her leg, causing her unnecessary pain and a delay[3] in treatment (3 years, 11 months).

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[1] The victim was a 57 year old woman with depression and a stroke. After the rape, the CNA paid the victim $2 to keep quiet. He was sentenced to 3 years in prison.

[2] The gapping, infected pressure ulcer, measuring 1 foot by ½ foot long, developed in the two months that the patient was at the facility. When she was admitted to the facility, she had no skin breakdown or pressure sores.

[3] The 80 year old patient was finally taken to the local hospital by her daughter after the daughter came for a visit and saw her mother's condition.

In response, the Department attributed the delays to, “staff turnover … due to retirements…” and assured Disability Rights California that the Department, “is working hard to complete its investigations and issue the citations (if applicable) in a timely manner.” To date, Disability Rights California continues to see unreasonable delays. In a recent substantiated complaint still pending release, the Department attributed delays to the case being reassigning three times, once when the primary investigator retired, then twice more when the persons assigned, “simply [could not] get to it anytime soon.”

A few examples include:

- On July 20, 2010, a 30 year old skilled nursing facility resident with paraplegia died from uncontrolled bleeding from pressure ulcers at his groin. Over two years later, the Department issued a Class A citation, citing the facility for failure to monitor the use of blood thinning drugs with this resident.

- In November 2007, two witnesses saw care staff at a psychiatric nursing facility smeared feces on a patient’s face and put it in his mouth. An investigation by the facility confirmed the incident. Nearly four years later, in August 2011, the department issued a Class B citation for $1000, citing the facility for failing to treat patients with dignity and respect and ensuring they are not subjected to physical and mental abuse by staff.

- In March 2008, a 36 year old resident with cerebral palsy and spastic quadriplegia was assaulted by a CNA employed at his six-bed ICF. The CNA was arrested and charged with dependent adult abuse. Four years later, L&C issued a Class B citation for $1000, finding the facility failed to protect the resident from physical abuse.

Disability Rights California acknowledges that thorough investigations take time; however, Disability Rights California finds it inexcusable for investigations into even the most complicated incidents to linger for more than several months. Cases often languish in a bureaucratic quagmire, awaiting review and approval by upper level management, medical experts, and attorneys.

These delays give the misimpression that these very serious incidents are not of concern because the Department has failed to act promptly or even remotely timely in ordering a plan of correction. In many cases, the facility administrative staff involved at the time are no longer employed at the facility, leaving the replacement staff to speculate at what corrective action might avoid a similar incident.

Delays also leave the public uninformed about recent critical events and concerning conditions at a care facility. This includes family members making decisions about where to entrust the care of a loved one who requires skilled nursing care.

Prompt investigation and requirements for corrective action must be the top priority of the Department to ensure similar events do not recur.

Concerns about Oversight of State Developmental Centers

Disability Rights California is equally concerned about delays in the Department's investigations of critical incidents at state developmental centers. In one notable case, three years lapsed between the resident's death and when the Department finally issued a Class A citation for staff failure to provide sufficient supervision. In another case, a developmental center resident was put into a coma for a week and a half reportedly after being assaulted by a CNA with a history of allegations of patient abuse. More than three years after this concerning event, the department has yet to issue a citation. In the meantime, the accused CNA has had his certification revoked.

In addition, Disability Rights California has been critical of the thoroughness of the Department's annual survey reviews of conditions. As you know, in 2012, the Department of Developmental Services agreed to remove some ICF units at Sonoma Developmental Center from federal certification due to the Department's finding of serious uncorrected care issues that had worsened over time, in part, due to lapses in oversight by the Department.

Earlier this month, the Department proposed similar federal enforcement action because of comparable deficiencies on the ICF units at Lanterman, Porterville, and Fairview Developmental Centers. A settlement agreement reached late last week between the Department and the Department of Developmental Services stayed termination of federal funding, pending

sustained corrective action at Porterville and Fairview, monitored by the Department. The Department will also monitor Lanterman Developmental Center to ensure services are provided as required during its closure activities.

Department complaint investigations and state and federal licensing surveys are the safety net that residents, family members, and the public rely upon to ensure that conditions in licensed care facilities do not slip to such distressing levels. It is troubling that the external inspection and review process failed, and failed for years.

Delays in Referrals to and Investigations of CNA Misconduct

Recently, Disability Rights California investigated the timeliness by which the Department's Professional Certification Branch completed investigations of resident abuse by CNAs in skilled nursing facilities. The Professional Certification Branch is a division of the Department that certifies CNAs, investigates complaints of misconduct and enforces disciplinary action.

Disability Rights California investigated the timeliness and outcomes of action taken by the Professional Certification Branch in 17 citations issued by the Licensing and Certification Division (L&C) of the Department that involved CNA misconduct. The cases investigated had been substantiated by the L&C and resulted in a citation.

In 12 of 17 citations that Disability Rights California investigated, there were significant delays in the referral of complaints to the Professional Certification Branch by L&C and/or in the Professional Certification Branch initiating or completing their investigation. Examples included:

- In August 2008, two staff members witnessed a CNA hit a 32 year old male with a psychiatric disability on the back of the head with a clipboard she was carrying. January 2012 (nearly 3½ years later), a Class B citation was issued with a penalty of $1000. In August 2012 (four years later), the Professional Certification Branch revoked the CNA's certification.

- In late November 2009, L&C was notified about six CNAs who lathered up seven female residents with A&D ointment over their

entire bodies as a prank for the incoming night shift. All six CNAs pled no contest to criminal charges of elder abuse. In mid-April 2010, L&C issued one Class B citation[4] for $1000. The Professional Certification Branch initiated their investigation over eight months later, in early August 2010.

- In March 2010, two CNA students witnessed a male CNA hit a 78 year old nursing home resident four or five times on the back of his head with the book. The following day, the CNA was overheard by the students threatening the resident and again hitting him on the back of his head several times. The Professional Certification Branch was notified by L&C over eight months later and revoked his CNA certification shortly thereafter.

Delays mean that abusive care staff remain certified and available to work in long term care facilities pending investigation and disciplinary action by the Professional Certification Branch. While the individual(s) responsible may be suspended or terminated at the facility where the incident occurred, because they remain licensed there is nothing to prevent them from working at a different facility.

Disability Rights California's Recommendations

1. **The Department must ensure that complaint investigations are timely completed and that findings and requirements for corrective action are promptly issued.**

Disability Rights California urges the Department to implement deadlines to complete investigations and publish findings of confirmed incidents of abuse, neglect, and other health and safety violations in long term care facilities, including those serving individuals with developmental and mental disabilities. The timeframes should be structured so that the most egregious incidents, those resulting in death or posing an imminent risk of serious harm, receive the most prompt attention and are quickly published. At the outside, Disability Rights California recommends the following timelines by which the Department should complete investigations and

[4] Disability Rights California questions why only one citation was issued when there were seven residents victimized.

publish the outcome of substantiated complaint investigations, including issuing any citations:

- within 90 days (of receiving notice of the incident) where the violation was the direct proximate cause of a resident's death;
- within120 days (of receiving notice of the incident) in cases where the violation poses an imminent danger or substantial probability of death or serious harm;
- within 180 days (of receiving notice of the incident) for all other substantiated complaints including those likely to cause significant humiliation, indignity, anxiety, or other emotional trauma to a patient.

These timelines allow adequate time for the Department to complete a thorough investigation while ensuring that the facility is required to promptly correct deficiencies contributing to the incident, thereby reducing the likelihood of recurrence. Promptly publishing findings also gives the public timely notice of problems at a facility. This includes family members and future residents trying to find a safe care facility for their loved one or themselves. When final citations are issued months or years later, it is difficult to know about current conditions and may give the false impression that the facility has had no recent critical events.

Investigations of resident abuse, neglect, injury, and death should not lag for years. Facilities must be promptly held accountable for conduct that contributed to the incident and be required to develop and implement steps, without delay, to ensure that such critical incidents do not recur.

2. The Department should ensure the timely referral of allegations of resident abuse by CNAs to the Professional Certification Branch.

The Department is generally notified within a few days of a known or suspected incident of resident abuse or neglect. These reports are directed to the L&C division. Disability Rights California urges the Department to ensure that incidents implicating a CNA are promptly referred to the Professional Certification Branch, even while pending the final outcome of the L&C complaint investigation.[5]

[5] Although beyond the scope of this hearing, Disability Right s California further recommends that the Department provide notice to other California health care

The Department should ensure that all citations that substantiate complaints of abuse or neglect by a CNA are immediately referred to the Professional Certification Branch. This is not only an added check to ensure that all incidents are reported, but also serves as a quality assurance measure regarding internal consistency in abuse investigations.

The Professional Certification Branch undoubtedly has a variety of factors that must be considered when taking disciplinary action. However, the threshold finding of culpability should not vary from the determination of L&C.

3. **The Department should ensure the timely completion of investigations into CNA misconduct by the Professional Certification Branch.**

The Department must ensure the timely completion of investigations of CNA misconduct by the Professional Certification Branch. Facts supporting disciplinary action are more likely to become stale and incentives for prompt compliance with corrective action by the CNA weaken with time.

In most cases, the facility in which the abuse occurred immediately terminated the CNA involved in the incident. However, pending the outcome of the Professional Certification Branch's investigation, the CNA is eligible to be hired by another care facility, unaware of the CNA's prior history of abuse. Therefore, timely investigations are imperative to protect residents from CNAs with a history of abusive or negligent interactions with residents under their care.

The Department should consider including information about a CNA's disciplinary history in the CNA certification verification page, including a summary of the confirmed underlying misconduct and entry into diversionary programs. This would allow potential employers and the family members hiring in CNAs to care for loved ones at home to know about a caregiver's track record.

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professional licensing or certification boards of substantiated adverse events proximately or directly related to the conduct of a licensee.

4. **The Department should periodically audit the referral and investigation process to ensure compliance with established timelines.**

The Department must develop and utilize internal quality assurance processes to monitor the thoroughness and timeliness at each step of their survey and complaint investigation process and identify problematic trends in a district office and/or across the Licensing system. This includes delays in upper level administrative review, medical consultation, and legal division approval.

The Department should periodically audit substantiated complaints by L&C of CNA misconduct to ensure the timely referral of complaints and completion of investigations by the Professional Certification Branch. The system should track the timeliness of referrals at each point within an abuse investigation timeline, including; (1) the date of the incident, (2) the date L&C received the complaint, (3) the date L&C investigators initially established that the misconduct involved a CNA (most likely at the time of their on-site investigation), and (4) the date the citation was issued. The Department should establish a system by which Department supervisors are notified of overdue investigations.