# Dangerous Caregivers:

## State Failed to Cross-Check Backgrounds, Exposing Elderly to Abusive Workers

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# Executive Summary

A San Diego certified nurse assistant ran into trouble in 2006 when she tried to transfer an 81-year-old nursing home resident from her bed to the shower. The resident's chart stated that two nurse assistants should always work together to move her to avoid a fall. But A.L. did it herself. When the resident fell, A.L. failed to tell a supervisor. She later told investigators that the patient, with a history of dementia, seizures and strokes, had not fallen. A.L. said she had merely "eased her onto the floor" when she could no longer support her weight.

The fall fractured the woman's left hip. Two months later, she died. "Unquestionably, this incident contributed to her demise," a report by the Department of Public Health concluded.

A.L. was fired. Later, she pled guilty to a criminal charge based on the incident. The Department of Public Health revoked her nurse assistant certification. The nursing home was cited by the state, and the family of the resident sued.

A few months later, however, A.L. was back working with aged Californians. She was cleared by the Department of Social Services, which was unaware of her history as a nurse assistant, to work as a caregiver at a different type of residential facility for the elderly. She continues to work there today.

Her case reveals a gap in how those who work with California's vulnerable elderly population are screened and monitored, the Senate Office of Oversight and Outcomes has found. It was one of at least 20 cases we discovered in which Social Services cleared caregivers to work in residential care facilities for the elderly, unaware that Public Health, which is part of the same state agency, had revoked the individual's nurse assistant certification for negligence, abuse, theft or other serious misconduct.

Our investigation focused narrowly on a sample of workers with uncommon names. A search using more exact identifiers unavailable to our office, such as Social Security numbers, would detect more.

In 2006, the Legislature passed a law that required the Department of Social Services to maintain a centralized database of workers sanctioned by administrative actions such as license revocations. The idea was that six state departments could consult the database

to find out if those who wanted to work with sensitive populations, such as the elderly, had ever gotten into trouble with other state regulators.

Four years later, the database does not exist. The Department of Social Services decided in the 2007-08 fiscal year that it would not seek money to comply with the new law, which was contingent on a budget allocation. In later years, as the state's budget deteriorated, Social Services did not consider seeking money for the centralized database, estimated to cost "in excess of $500,000." Nor did it inform the Legislature that the database would not be built, deciding on its own that the state's cash crunch would mean shelving the project while it pursued less costly steps.

In February three months after the oversight office requested information for this report, Social Services and Public Health signed an agreement to start sharing monthly lists of caregivers and certified nurse assistants who have been disciplined. At that time, officials told us that they lacked the resources to check workers already in facilities to find out if they had been sanctioned while in another health care or social service occupation.

On the eve of this report's publication, Social Services informed the oversight office that, in response to our findings, it had decided to check current workers in residential care facilities for the elderly. The department said it was in the process of compiling the results and did not yet have a full picture of how many workers the search identified or what actions the department would take.

The department's effort falls short of the system envisaged by the Legislature. It does not include the four other state entities named in SB 1759. And it does not cover workers in other types of facilities licensed by Social Services, such as adult day centers and residential care facilities for the chronically ill.

Together, nurse assistants and caregivers provide much of the day-to-day hands-on care in California's facilities for the elderly, from big nursing homes to six-bed board-and-cares. They also work with other vulnerable populations, helping with eating, bathing, dressing and getting around. They number more than 300,000.

The investigation by the Office of Oversight and Outcomes found that nurse assistants stripped of their certifications have sought work as caregivers, and that the system of background checking, with its focus on criminal history, did not detect their earlier misconduct.

Among the cases identified by the oversight office:

- J.K., a nurse assistant and psychiatric technician assistant, was fired and decertified after a co-worker watched her engage in a series of abusive acts with her blind, developmentally disabled clients. She struck one in the head with a puzzle tray, took one client's hand and used it to hit another, and punched a third in the stomach,

according to investigations. Five months later, she got a criminal clearance and went to work at an 11-bed board-and-care, where she is still employed.

- M.A. lost her certification as a nurse assistant after an investigation found that she had stolen from nursing home residents, family and staff. Nine months later, the Department of Social Services cleared her to work as a housekeeper in a 99-bed residential facility for the elderly.
- A 22-page report found that J.V. pulled a nursing home resident up by the neck and grabbed her hair. J.V. is "a very dangerous C.N.A. (certified nurse assistant) and should not be working in this industry," the state investigator wrote. J.V., however, remains on the Department of Social Services database of people cleared to work in residential care facilities for the elderly.

Although our investigation focused on decertified nurse assistants who became caregivers, we also found evidence that the problem extends to other health care and human service professionals. Two vocational nurses and a pharmacy technician, stripped of their licenses, went to work as caregivers in homes for the elderly. Social Services also cleared as caregivers a nurse who lost her license in Nevada and a private citizen who took part in a Medicare scam in Los Angeles. It is likely that we would have found similar cases if we had examined the many workers cleared by Social Services to work in the other facilities it licenses.

In other cases we Social Services cleared individuals to work in homes for the elderly despite knowing about criminal convictions that had led them to lose their nurse assistant certifications.

Social Services and Public Health both have latitude to allow those with criminal convictions to work. Because they are governed by different statutes, officials say, they may come to different conclusions about an individual's fitness to work in a facility for the elderly. Yet our investigation found at least one case that raised questions about the logic of the two departments coming to different conclusions about the same individual. Social Services allowed M.B. to continue to run a six bed board-and-care after a criminal conviction for battery and other misconduct that led Public Health to conclude that he "may pose a potential risk to the health, safety and welfare of residents."

Lastly, the investigation found that the two departments could do much more to make disciplinary information available to the public, and that their current policies are at odds with most other large states. Public Health's on-line nurse registry, for instance, requires that the user know not only nurse assistants' names, but also their certification numbers. Public Health does not provide any public information about the circumstances that led to a disciplinary action.

Our findings point to the need for a comprehensive system to allow state operations to share information about those who work with sensitive populations such as the elderly – a need that has been identified repeatedly over the past six years.

# Background

The regulation of workers in nursing homes and other long-term care facilities for the elderly has become more pressing as their numbers grow with the aging of the population. In 2009, the category of workers that includes certified nurse assistants swelled to more than 2 million in the U.S., according to the Bureau of Labor Statistics – a 36 percent increase from nine years earlier.

California has seen a proliferation of residential facilities for the elderly, sometimes called board-and-cares or assisted living. There were 7,648 such facilities in 2008, according to the U.S. Administration on Aging – an increase of 18 percent in only four years.

These non-medical facilities provide help with daily living, such as dressing and eating, as well as housekeeping and dispensing of medications. But they are not permitted to take residents who need round-the-clock care like that offered in nursing homes. They rely on low-paid caregivers to provide many of these services. More than 140,000 individuals have been cleared to work in residential care facilities, according to a Department of Social Services database, though not all of them are currently employed.

In nursing homes, certified nurse assistants are responsible for much of the same day-to-day care. But their duties go beyond those of caregivers in residential facilities. Working under the supervision of nurses, they are responsible for checking blood pressure, temperature and the like. To become certified, they must complete 160 hours of training in classrooms and in the workplace. Pay rates are generally higher than those for caregivers in non-medical residential facilities. Most of the state's 196,935 active nurse assistants work in nursing homes.

## Criminal checks

Both categories of workers must submit to criminal background checks. Nurse assistants are certified by the Licensing & Certification Division of the Department of Public Health. Caregivers are regulated by the Department of Social Service's Community Care Licensing Division. The two departments are required by law to conduct criminal

background checks and bar those who have committed certain offenses. The lists of crimes that disqualify an applicant vary between the two departments, but include many of the same offenses.

For crimes not specified in statute, both departments may exempt applicants if, for instance, the crime occurred a long time ago, was not serious or the applicant has taken steps to reform.

In its application form for nurse assistants, Licensing & Certification asks applicants if they have ever been the subject of an administrative action, such as a license revocation, by another governmental agency. But the department says it does not conduct independent checks to verify the statement, unless it has reason to believe that the applicant lied. Officials told this office that they have no process in place to make such checks, and don't do it as a matter of routine.

Community Care Licensing currently does not ask would-be caregivers whether they have run into trouble with other licensing boards. But in response to the findings of this report, the department plans to do so, and will seek regulations if necessary. In addition, Community Care Licensing is in the process of changing the form filled out by those who want to license new facilities to ask whether they have been the subject of administrative actions such as a revocation by entities outside of Social Services. Previously, the forms asked only about administrative actions within the department.

Both departments may deny applications or take disciplinary action against those already working in facilities for the elderly. Conviction of a crime is one trigger. Both departments are supposed to receive updates from the Department of Justice if a worker is arrested or convicted of a new crime – the so-called "rap-back" system.

State law specifies how the two departments discipline wayward workers. Both have the power to ban workers convicted of crimes, as well as those whose conduct makes them a danger to their elderly charges, even if they are not convicted of a crime. Health & Safety Code Section 1337.9 allows the Department of Public Health to take action against certified nurse assistant applicants or those already in facilities for a variety of causes short of a criminal conviction. Foremost among these is unprofessional conduct, "including, but not limited to, incompetence, gross negligence…, physical, mental or verbal abuse of patients, or misappropriation of property of patients or others."

Likewise, Health & Safety Code Section 1569 et. seq. lays out the Department of Social Service's procedures for "excluding" individuals from the facilities it licenses, including residential care facilities for the elderly. The procedure applies not only to caregivers, but to applicants who have not yet started working and anyone in a facility who is not a client, such as relatives of the licensee. The department can require licensees to exclude these individuals for a variety of reasons, including engaging in behavior that "is inimical to the health, morals, welfare or safety of either an individual in or receiving services from the facility…"

## The Two State Departments that Oversee Facilities for the Elderly

| | OVERSEEN BY | LICENSES | WORKERS APPROVED | POWERS |
|---|---|---|---|---|
| **Department of Social Services:** | Health and Human Services Agency | 85,000 facilities and programs that serve children, the elderly and others | 700,000 caregivers who work in facilities, licensees and others present in facility | Health and Safety Code Section 1569 et. seq. lays out discipline of workers for criminal convictions or misconduct revealed by a department investigation |
| **Department of Public Health:** | Health and Human Services Agency | 1,400 nursing homes | nurse assistants, home health aides, hemodialysis technicians | H&S Code Section 1337.9 details discipline of workers for convictions or misconduct revealed by a department investigation |

The Department of Public Health, on its Web site, maintains a database of certified nurse assistants that employers can consult to see if a prospective employee has been sanctioned. The database requires both the name and the certification number.

The Department of Social Services has a database of excluded caregivers, but it is not posted publicly. "Budgetary constraints have hampered the Department's ability to develop these types of consumer tools," the department wrote in response to a question from the oversight office.

## Repeated calls for centralized licensing

Since 2004, several reviewers of state operations have proposed consolidating the many state operations that license or otherwise regulate health and social service workers. While one impetus has been to reduce costs, the reports stress that sharing information would help weed out those who might do harm.

In a 2004 report, "Real Lives, Real Reforms: Improving Health and Human Services," the Little Hoover Commission called for consolidation of the separate licensing and certification operations in five departments. The California Performance Review, commissioned by Gov. Arnold Schwarzenegger to propose government reorganization, followed up later that year with a similar recommendation.

"Centralized databases would help to protect consumers from providers that have been banned from delivering services in any consumer setting," the performance review found. The non-partisan Legislative Analyst's Office later wrote that the recommendation has "a great deal of merit."

In 2006, Senate Bill 1759, proposed by the Schwarzenegger administration, incorporated the recommendation.

Among other provisions, SB 1759, by Senator Roy Ashburn, authorized five departments – Aging, Health Services, Alcohol and Drug Programs, Mental Health and Social Services – and the Emergency Medical Services Authority to share information about workers who had been the target of administrative actions such as suspensions and revocations.

The bill would protect the safety of clients, Ashburn said at the time, by allowing departments to act on information gleaned from earlier administrative actions. SB 1759 required the Department of Social Services to set up and maintain a centralized system for tracking administrative actions, to be used by the other state operations for background checks. The bill authorized Social Services to charge a fee to the other offices to cover its costs. It made the data center contingent on money being appropriated in the state budget. SB 1759 passed by a vote of 32 to 0 in the Senate and 74 to 2 in the Assembly before being signed by Gov. Schwarzenegger.

## Project never got off the ground

Even though the administration proposed the project to Senator Ashburn, Social Services decided the next year not to seek a budget allocation. The department declined to say where the decision was made, whether by the department's own leadership or at other levels of the administration, such as the Health and Human Services Agency or the Department of Finance. After the project failed to make it into the 2007-08 budget, the state's fiscal situation continued to deteriorate and Social Services didn't consider proposing it for ensuing budgets. The department initially won approval for 2.5 positions to oversee data sharing. But later reductions eliminated those positions. Because the data center was contingent on an appropriation in the budget, and the department was pursuing other steps that didn't cost money, Social Services saw no need to inform the Legislature.

The data-sharing project also faced technological hurdles, said Jeffrey Hiratsuka, a deputy director at the Department of Social Services. The various departments kept their data in different formats.

"Each department would have to go out and seek their individual funding pieces to automate their own processes so they could interface with us," Hiratsuka said. "And unfortunately…it was tough for everybody to get the resources to do that."

On Feb. 10, three months after the oversight office first contacted the two departments for this report, Social Services and Public Health signed an interagency agreement to once a month share lists of workers who have been excluded from facilities or decertified as nurse assistants.

On February 16, 2010, officials told the oversight office that they lacked the resources to do the same kind of checking of caregivers already working in residential care facilities for the elderly – although they did plan to examine the cases identified by the oversight office. A month later, just before publication of this report, the departments revealed that they had done the background checks for existing workers. Social Services said it did not yet have a full picture of how many individuals the search identified or how it would proceed in those cases.

These moves, while laudable, fall short of the database called for by SB 1759. The agreement does not include the four other state entities included in the legislation. And it does not cover the workers in the many other types of facilities licensed by the Department of Social Services.

# Methodology

While researching the state Long-Term Care Ombudsman program in 2009, the oversight office interviewed frontline workers in elder abuse who said that certified nurse assistants who lost their certification could easily find work at other facilities for the elderly licensed by the Department of Social Services. Because those caregiver jobs required only a criminal background check, the sources said, the department and the facilities never found out about an administrative action such as the state revoking a certification.

To determine if this was occurring, and how widespread the problem might be, the oversight office obtained two databases. One, compiled by the Department of Public Health, included the names of revoked certified nurse assistants. The other, from the Department of Social Services, contained the names of caregivers who had either cleared the criminal background check, or received an exemption allowing them to work in a residential care facility for the elderly despite a criminal history.

We linked the two databases to find names that occurred in both. The query produced hundreds of results. But many of the names were so common that it would not have been feasible, given the lack of other data such as dates of birth and Social Security numbers, to ascertain whether they were the same person. Instead, we focused on uncommon names and used other public databases to verify identities. In several cases, workers contacted by phone confirmed that they had previously worked as nurse assistants and had been decertified by Public Health.

Given this methodology, it would be difficult and misleading to draw statistical conclusions about the prevalence of the phenomenon. However, even the narrow review we conducted found at least 20 nurse assistants who lost their certifications for improper conduct, but had been cleared to work in residential care facilities for the elderly.

The Department of Public Health provided investigative reports on the individuals we identified. The department now says it erred in releasing those reports, which it believes to be subject to an exemption to the California Public Records Act.

We chose to identify workers only by their initials because the purpose of the examination was to identify gaps in the system rather than focusing on individuals. The full names were provided to the Department of Social Services in order to obtain more information about the workers' current whereabouts. The department has since been conducting its own investigations of those workers.

# Results

## Decertified nurse assistants who became caregivers

One of the most serious cases involved J.K.

She worked as a certified nurse assistant at Sonoma Developmental Center. As such, she was also a state employee, with the title of psychiatric technician assistant.

On May 5, 2002, J.K. was on duty with another nurse assistant, overseeing eight to 10 blind, developmentally disabled clients in an activity room.

The other nurse assistant later reported that she witnessed a series of abuses. J.K. took one client's hand and used it to hit another on the head. She snapped a rubber glove in a woman's face. The client complained, prompting J.K. to pour ice down her back and, later, hit her in the head with a puzzle tray. Twice, she threw a softball, overhand, into the stomach of a client who had been sleeping in a rocking chair. When a client was slow getting up from his chair, she punched him hard in the stomach and told her co-worker, "This is how I get him up." She slapped another who objected to wearing a nightgown. The blow turned the woman's head and caused her hair to fly. The next morning, she had a bruise under her left eye.

The coworker told investigators the incident caused her to lose sleep. The next day, she reported the abuse and J.K. was fired. The Department of Health Services issued a citation, and a referral was made to the Sonoma County District Attorney's office, which apparently did not pursue the case - there is no record of a criminal charge against J.K. She later appealed her decertification in Sacramento Superior Court, but a judge sided with the Department of Health Services.

In early 2003, three weeks after Health Service's investigator filed a report, J.K. was cleared to work as a caregiver in residential care facilities for the elderly. In 2006, she went to work for an 11-bed board-and-care where, according to a personnel report, she was assigned to the 7 p.m. to 7 a.m. shift Friday through Sundays. The board-and-care

is approved to take residents with dementia, as well as those unable to walk or suffering from terminal illnesses.

The Office of Oversight and Outcomes contacted her at the board-and-care. J.K. confirmed that she was the person who got into trouble at the Sonoma Developmental Center.

"Something happened they accused me of," she said. "I didn't do it. They (the center's clients) loved me so much." She said she has had no problems at the board-and-care, but wishes she could make more money as a certified nurse assistant.

In addition to the cases of M.A. and J.V. outlined in the Executive Summary, our investigation found the following:

- P.J. lost her job and her nurse assistant certification in 2009, after other workers at her facility reported that she failed to clean feces off a resident's back, buttocks and clothes and told a resident with a hip fracture to get into bed herself, contrary to instructions that the resident not put any weight on her hip. The resident took two steps then fell onto one knee and both hands on the bed, a physical therapist reported. The state's investigator found the incidents, along with other write-ups in her personnel file, evidence of "overall incompetence and un-trainability." P.J. had previously worked as a caregiver in a non-nursing facility. About three months after the events that led to her firing and decertification, she got a new criminal background clearance to work at a 110-bed residential care facility in Modesto, where she still works. In an interview, P.J. said she was falsely accused and didn't know how to appeal. By the time she found out, she said, she was told it was too late. P.J. said no one at her new job ever asked her about her experience as a certified nurse assistant.
- K.S. was fired and decertified as a nurse assistant in 2008 for taking a blind resident's ATM card and withdrawing $100 in cash. A report was made to the Sacramento County Sheriff's Department, but criminal charges were not filed. Afterwards, K.S. worked in the kitchen of the 106-bed residential facility. She has since quit, a facility manager said. But she remains on the Department of Social Service's database of workers cleared to be employed by residential care facilities for the elderly.
- The Department of Public Health decertified R.P. for slapping an 83-year-old nursing home resident and pulling her hair when the resident struggled during a diaper change. A housekeeper reported that the resident cried as a result of the abuse. A month after R.P. was fired by the facility, she got a clearance to work at a residential care facility for the elderly. The oversight office located R.P. at a Sacramento adult day care facility. She said she is working as a trainer, overseeing clients doing volunteer work and arts-and-crafts activities. She said the nursing home resident who accused her was not in her right mind. No one, she said, has asked her about the incident.
- E.G. was decertified as a nurse assistant in 2004. Witnesses told an investigator that she abused a resident after the wheelchair-bound man kicked her in the chest. One said E.G. hit the man repeatedly with both hands. Another said E.G. took off her shoe and used it to bang the side of the man's wheelchair. The state cited the facility. The

Department of Justice investigated, but apparently never prosecuted, perhaps because one of the witnesses declined to cooperate. Two years later, E.G. was cleared to work at a six-bed board-and-care in Concord. Repeated calls to the board-and-care and a home number for E.G. were not returned.

- C.P. lost her nurse assistant certification in 2005 after failing to report a resident falling from a patient lifting device, and then lying about it when confronted. The patient had said she was terrified and humiliated by the lift, but C.P. insisted that she be moved in it, the investigation found. The facility intended to fire her, but allowed C.P. to resign. Within a month of resigning, she renewed an earlier caregiver clearance to work at a 153-bed residential care facility in Walnut Creek. A worker confirmed that C.P. still works there.
- A.T. was decertified as a nurse assistant after an investigation in late 2007 found that she had borrowed $500 from a facility resident. The resident also gave her money to pay for a blender. The resident became concerned when he didn't see A.T. for several days and then found out she had quit. A.T., confronted about the loan, returned the money. At that point, A.T. had been already been cleared for several years to work as a caregiver in residential facilities for the elderly. Shortly after her nurse assistant certification was revoked, she went to work at a six-bed board-and-care in Oceanside.

If the Department of Social Services had known about these incidents, it would not necessarily have excluded the workers from residential facilities for the elderly, Hiratsuka said. But the information likely would have prompted it to investigate further.

"We have to prove to an administrative standard that whatever the individual did jeopardizes the health and safety of someone…," he said. "But obviously, it starts our thought process of investigating." The department has reviewed the cases discovered by the oversight office.

## Missing criminal conviction

In one case we examined, Social Services was unaware of a criminal conviction that Public Health knew about.

Both departments are supposed to get criminal background information from the Department of Justice. But in the case of A.L., detailed in the Executive Summary, no one told Social Services that the nurse assistant had been convicted of a criminal charge. This breakdown occurred even though the criminal case stemmed from the same incident that led Public Health to take away her nurse assistant certification – the negligent handling of a resident who broke her hip, contributing to her death.

Officials could not explain how it occurred – whether the court failed to forward the information to the Department of Justice, the Department of Justice neglected to notify Social Services, or something else went wrong. In any case, A.L. was cleared to work a few months after the incident that led to her firing and criminal conviction at a six-bed board-and-care. In an interview, she said her current employer knows of the circumstances that led to her losing her nurse assistant certification.

## The two departments reach different conclusions

The oversight office's review found cases that raised an issue separate from the two departments' failure to share information through a centralized database. In these 10 cases, both operations knew about a criminal conviction. But they came to different conclusions about whether the offense should disqualify an individual from working in a facility for the elderly.

The two departments are governed by different sections of the Health and Safety Code. Officials said this could lead to different outcomes for individuals with criminal convictions. There are variations, for instance, in the list of crimes that require a person to be banned from working in state-licensed facilities.

The two departments have different procedures for deciding if and when to allow an individual to be certified or cleared to work in a facility despite a criminal history. The Health and Safety Code allows Public Health to certify nurse assistants if misdemeanor convictions have been dismissed upon completion of a sentence, or if a felon has obtained a certificate of rehabilitation. Social Services can allow caregivers to work in facilities despite convictions if it has "substantial and convincing evidence" that they are of good character.

In an interview, Social Services officials explained why it clears caregivers whose crimes have led Public Health to revoke nurse assistant certifications. Public Health has "zero tolerance" for offenses such as driving under the influence and substance abuse, they said. Social Services, by contrast, may grant exemptions to individuals who have committed those offenses, often also imposing conditions. Someone with a DUI, for instance, might be forbidden from driving on the job.

Our review found cases in which former nurse assistants worked as caregivers after convictions for shoplifting, making false insurance claims, and theft of welfare benefits. In some cases, we could not determine the nature of the criminal conviction because Public Health redacted the offense, the court and the date, and the conviction could not be found on public databases. At least two of these cases involved felonies.

One case raised questions about the logic of the two state operations reaching different conclusions about the same individual.

M.B. was a certified nurse assistant and the licensee of a six-bed board-and-care when he was convicted in 2005 of misdemeanor battery. According to a police report, he pushed his sister into a pole and punched his brother in the face during an argument. He pled no contest, and was sentenced to two years of formal probation.

Several days later, his sister obtained a restraining order. She alleged that M.B. had a history of violence, including beating his former wife and molesting his daughter. The

sister raised questions about whether M.B. was neglecting to care for his mother, whose apartment he and his wife shared.

Public Health responded to the criminal conviction by revoking M.B.'s certification as a nurse assistant.

"The relationship between the conviction and the duties of a nurse assistant is considered significant," according to the letter it sent him.

M.B. also tried to deceive the department by submitting a letter from an associate attesting to his character that had been written five years earlier for a different purpose. M.B.'s actions "portray a pattern of deception, which can again result in criminal action," Public Health's investigator found. M.B. "may pose a potential risk to the health, safety and welfare of residents."

Social Services saw it differently. It issued M.B. an exemption in July 2006, a month before Public Health took away his certification, allowing him to continue running his six-bed board-and-care despite the conviction. Social Services would not disclose its file on M.B. or discuss its reasoning in granting him an exemption.

Since then, M.B.'s board-and-care has run into problems. In 2008, in a routine inspection, Social Services found several deficiencies at the facility, which has special permits to care for residents who can't walk or suffer from dementia or a terminal illness. The six-bed home was over its capacity because it had allowed a seventh resident for more than a year. A staff member didn't have a criminal clearance. The inspector found expired medications and other irregularities, such as prescription labels being altered or drugs protected only by an easily opened toddler lock. M.B.'s wife was helping a resident with insulin injections, contrary to regulations that require a medical professional.

"There is concern regarding the Administration and Operation of this License," the inspector wrote. The facility remains in business.

While it is beyond our office's purview to conclude whether Social Services made the right decision in M.B.'s case, at the very least the circumstances suggest that the department should explain how it applies its criteria for granting exemptions, and consider making the process more open to public scrutiny.

## The problem extends to other health care professionals

The oversight office focused much of its investigation on certified nurse assistants and caregivers in residential care facilities for the elderly because these two large categories of workers often overlap – nurse assistants become caregivers and vice versa. The two groups provided a useful test for gaps in the state's screening of health and human services professionals.

The same technique could have been applied to the many other categories of workers licensed, certified or otherwise overseen by the state.

The California Performance Review found that departments, agencies and boards oversee more than 50 categories of health and human services professionals - from registered nurses to In-Home Supportive Services providers.

Our review found evidence of the same sorts of enforcement gaps among these workers.

The Inspector General of the U.S. Department of Health & Human Services maintains a database of workers banned from working in facilities that get federal Medicare or Medicaid money because of license revocations or other administrative actions, as well as criminal convictions. We compared that data to the database we got from the Department of Social Services of workers cleared to work in residential facilities. The search found three licensed vocational nurses and a pharmacy technician who lost their licenses for misconduct, but were approved to work as caregivers in residential care facilities for the elderly.

Again, our search focused narrowly on individuals with uncommon names. We were unable to estimate how many workers might have been found using more definite identifiers, such as Social Security numbers, not available to the oversight office.

Among the cases we found:

- A.M. was stripped of her vocational nurse license after she failed in 2002 to notify a doctor or registered nurse that a 7-year-old boy brought to the hospital after being hit by a car had taken a turn for the worse. The boy died, and the nursing board found A.M. guilty of incompetence or gross neglect. Three years after that decision, Social Services cleared A.M. to work as a caregiver. Her most recent employer, according to Social Services records, is a six-bed board-and-care in Riverside.
- The vocational nursing board found D.C. guilty of gross negligence for failing to oversee the dispensing of medications at a 200-bed assisted living facility in Oceanside. For two-and-a-half months in 2003, residents didn't get their drugs, records were missing or inaccurate, and medications were destroyed without the required number of witnesses. A year after the events that led the nursing board to revoke D.C.'s license, Social Services, which licensed the facility where she got into trouble, cleared her to work as a caregiver in another of its facilities.
- The Board of Pharmacy took away D.B.'s pharmacy technician registration in 2007 after she stole 11,000 tablets of a prescription pain-killer over seven years to give to her disabled husband. Two years later, Social Services cleared her to work in a 128-bed assisted living home in Roseville.
- E.C., who was not a health professional, found her way onto the federal database of excluded workers after she and eight others were charged with running a scam that billed Medicare $2 million for bogus medical procedures. Two years after being sanctioned by the federal government, E.C. was cleared by Social Services to work in residential homes.

- W.W. lost her practical nurse license in Nevada before going to work as a caregiver in California. The Nevada nurse board revoked W.W.'s license in 2007 after she partially removed a patient's catheter line without a doctor's orders and then tried to re-insert it. That same year, Social Services cleared her to work in facilities in California.

In an interview with the oversight office, Social Service officials said they do not routinely exchange information with the boards that license nurses and other health care professionals.

Recently, Social Services was given responsibility to clear another large category of caregivers – 376,000 In-Home Supportive Services workers. We found one case that suggests Social Services and Public Health should share information on these workers as well, even though Social Services currently lacks the authority to disqualify IHSS workers for anything but conviction of one of three crimes – elder abuse, child abuse or fraud.

S.T. was decertified as a nurse assistant in 2003 after one conviction for battery and another for petty theft. Despite losing her nurse assistant certification, S.T. went on to become a provider for IHSS, which aims to keep people out of nursing homes by helping them with daily activities in their homes. Two years later, S.T. was back in court again, convicted of continuing to collect IHSS money after her client had gone to jail. S.T. was sentenced to four months in jail and ordered to give back $1,237 to IHSS.

Last year's budget, for the first time, required the state to conduct criminal background checks of IHSS providers and disqualify those convicted of child abuse, elder abuse or fraud. That step would not have prevented S.T. from being approved, because she was not convicted of those crimes. Despite recent changes in the law, a worker like S.T. today would be free to work as an IHSS provider despite being stripped of her nurse assistant certification.

Social Services does have the authority, however, to exclude workers for misconduct that does not lead to a criminal conviction.

Nancy Reagan of the California Association of Health Facilities endorsed the idea of a centralized system. "The whole thing needs to be looked at in a comprehensive approach rather than piecemeal," she said. "We don't support a system that allows people to move back and forth."

She added, however, that the association, which represents 1,250 licensed health facilities, does not support paying additional fees to support such a system, because the facilities are already paying for the nurse assistant registry.

## Barriers to public disclosure

Not only do state operations have a history of failing to share information – they also make it hard for the public to find out about disciplinary actions against the two categories of workers we investigated.

The Department of Public Health maintains a searchable on-line database of certified nurse assistants, which discloses whether an individual is in good standing or has been the subject of disciplinary action. This database, however, requires the nurse assistant's certification number. It cannot be searched with the name alone.

The department says the database is meant to be used by employers, who know the nurse assistant's certification number. If family members of nursing home residents, or residents themselves, want to check on a certified nurse assistant, they can ask the facility for the certification number, they said. The department says it requires certification numbers because it prevents people from searching the database to find a similar name, and then using the certification information to pass themselves off as nurse assistants.

The department's policy contrasts with the practice in most other big states. Among the ten biggest states, only California, Ohio and North Carolina require information other than the name to search on-line registries of nurse assistants. New York, Texas, Florida, Illinois, Pennsylvania, Michigan, and Georgia have no such requirement.

Within the state of California, other entities that license health care professionals – from acupuncturists to registered nurses - also allow searches just by name. Some, such as the California Emergency Medical Services Authority, do not.

What's more, the Department of Public Health is at odds with many other regulators in providing no information about a disciplinary case other than the certificate status of a nurse assistant.

In California, members of the public can find out if a nurse assistant's certificate has been revoked or suspended, assuming they know the certification number. But they can't find out anything about the circumstances of the case – whether the nurse assistant was disciplined for failing to take a continuing education class, say, or something far more serious such as theft, physical abuse, or a criminal conviction. Such information could be of interest to facilities considering hiring a former nurse assistant as a caregiver, residents of facilities or their families, members of the public or researchers looking at misconduct in nursing homes.

The department provided investigative reports to our office, after redacting information such as the victim, the facility, and witnesses. But several weeks later, the department said it had made a mistake, and that it would return to its longstanding policy of not disclosing anything beyond the certification status listed in the on-line registry. It cited

a provision of the California Public Records Act that exempts investigatory records from the requirement to disclose government records to the public.

Other entities that license or certify health and social service workers release much more information about disciplinary cases. Some of them do it directly on their Web sites. Most or all of the boards under the Department of Consumer Affairs provide accusations or final orders in disciplinary cases against health care professionals, whether they resulted from a criminal conviction or the board's own investigation. The Board of Registered Nursing, the Board of Pharmacy and the Medical Board are among those that link to background materials on their Web sites.

We checked with three other large states - Texas, Illinois and Florida. All three provide some kind of background documentation about disciplinary cases involving certified nurse assistants. Texas, for instance, will give out investigative reports after redacting sensitive information. Florida releases a final disciplinary report describing the facts that led to the action.

In response to a question from the oversight office, Public Health said that the idea of providing summary information on disciplinary cases "is worthy of consideration..., taking into account the specific privacy requirements imposed by state and federal law."

The Department of Social Services also falls short of what many other regulators tell the public. It does not offer any information about caregivers on its public Web site. The department provided the oversight office a database of caregivers cleared to work in residential care facilities for the elderly, but said that this required a worker to write a "mini-program" to extract the data.

Unlike Public Health, Social Services, upon request, discloses the circumstances that led a caregiver to be excluded from its facilities. These facts are contained in accusations and final orders from the cases. The documents, however, are not available on its Web site.

# Recommendations

The Senate Office of Oversight and Outcomes suggests that the Legislature consider the following options.

- Enact legislation requiring the Department of Social Services and the Department of Public Health to identify individuals working in all facilities they license who have been subject to administrative actions. While not requiring the departments to exclude those individuals from state-licensed facilities, the legislation could mandate that they review the cases and determine the best course for protecting residents.
- Ask the Department of Social Services to come up with a new, more detailed estimate for implementing SB 1759 of 2006, and consider including an appropriation in the 2010-11 budget.
- Strengthen and better define the statute that lays out Department of Social Services procedures for barring individuals convicted of crimes to work in facilities licensed by the department. Require the department to provide more public information on its reasons for granting exemptions to workers.
- Ask the Department of Social Services to report on the feasibility of putting its database of caregivers cleared to work in facilities on its Web site.
- Require the Department of Public Health to revise its Web site to allow the certified nurse assistant registry to be searched with only a name.
- Require the Department of Public Health to release background information on cases that have led to disciplinary actions against a certified nurse assistant.
- Amend the statute created by SB 1759 of 2006 to expand information sharing on health care and social service workers to include other boards that license workers, particularly those under the Department of Consumer Affairs.
- Enact legislation allowing the Department of Social Services to exclude In-Home Supportive Services workers if they have been subject to administrative actions in other health care or social service occupations.

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