SENATE OFFICE OF OVERSIGHT AND OUTCOMES

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State's failure to cross-check caregiver backgrounds puts elderly in danger, report finds

SACRAMENTO— The state exposed elderly residents in long-term care facilities to dangerous caregivers by failing to put into practice a 2006 law that called on departments to check each other's background records, according to a report issued today by the Senate Office of Oversight and Outcomes.

The investigation discovered at least 20 cases in which individuals who lost nurse assistant certifications because of misconduct, primarily in nursing homes, were cleared to work in a different type of facility for the elderly, also licensed by the state. The cases, which resulted from a targeted search involving only a subset of workers in one type of facility, reveal a gap in how those who work with vulnerable Californians such as the elderly are screened and monitored.

The state's 197,000 nurse assistants provide much of the hands-on care in nursing homes and other health care facilities. Some of those stripped of their certifications found work as caregivers in residential care facilities for the elderly, sometimes called board-and-cares or assisted living.

Among the workers, identified in the report by their initials:

- J.K. lost her nurse assistant certification after a co-worker reported that she abused her blind, developmentally disabled clients, including hitting one in the head with a puzzle tray and throwing a softball, overhand, into the stomach of another who had been sleeping in a rocking chair. Three weeks after a Department of Public Health investigator filed a report, the Department of Social Services cleared J.K. to be a caregiver in residential care facilities for the elderly. She now works at a small board-and-care.
- A.L. tried moving a patient by herself, despite a notation on the 81-year-old's chart that she had to be transferred by two workers to avoid a fall. The resident fell and broke her hip, contributing to her death two months later. A.L., who failed to report the fall, lost her nursing aide certification and her job, and was convicted of a crime. The state issued a citation, and the family of the woman sued the facility. A few months later, Social Services cleared her to work as a caregiver in a residential facility for the elderly.

- M.A. lost her nurse assistant certification for stealing from nursing home residents, family and staff. Nine months later, Social Services cleared her to work as a housekeeper in a 99-bed facility.

“There is no excuse for allowing people with known histories of abuse to work in residential care facilities for the elderly or as caregivers in any other setting, ” Michael Connors, long-term care advocate for California Advocates for Nursing Home Reform, said in response to the report’s findings.

In all of these cases, Social Services was unaware of the earlier misconduct. Although it obtained criminal histories on applicants, the department did not check to see if they had been sanctioned by other state entities that oversee health care and human service workers.

Senate Bill 1759 of 2006 required Social Services to set up a centralized database of administrative actions, such as license revocations. The database, contingent on a budget allocation, would have allowed six state entities that license or certify health and human service workers to check each other’s records before clearing applicants.

Faced with a deteriorating state budget, Social Services decided not to seek funding for the project, which had been proposed by the administration in response to several reports calling for centralized regulation of those who work with vulnerable populations.

Three months after the oversight office contacted the departments for its report, available here, Public Health and Social Services signed an agreement to exchange disciplinary actions against certified nurse assistants and caregivers in residential care facilities for the elderly. The agreement falls short of the centralized database required by SB 1759. It does not include the other four state entities named in the legislation. Nor does it cover workers in the many other types of facilities licensed by the Department of Social Services.

“It is about time,” Connors said of the decision to screen workers in one type of facility.

The report, “Dangerous Caregivers,” found evidence that the problem extends to other health care professions. For instance, three vocational nurses who lost their licenses for negligence or other misconduct were approved to work as caregivers in residential care facilities for the elderly. Likewise, a pharmacy technician who stole 11,000 tablets of a prescription painkiller was cleared two years later to work at an assisted living home.

The report offers several options for the Senate, including legislation requiring the departments to screen those working in all their facilities, not just residential care facilities for the elderly. A hearing of the Senate Subcomittee on Aging and Long-Term Care has been scheduled to review the report’s findings on March 24.