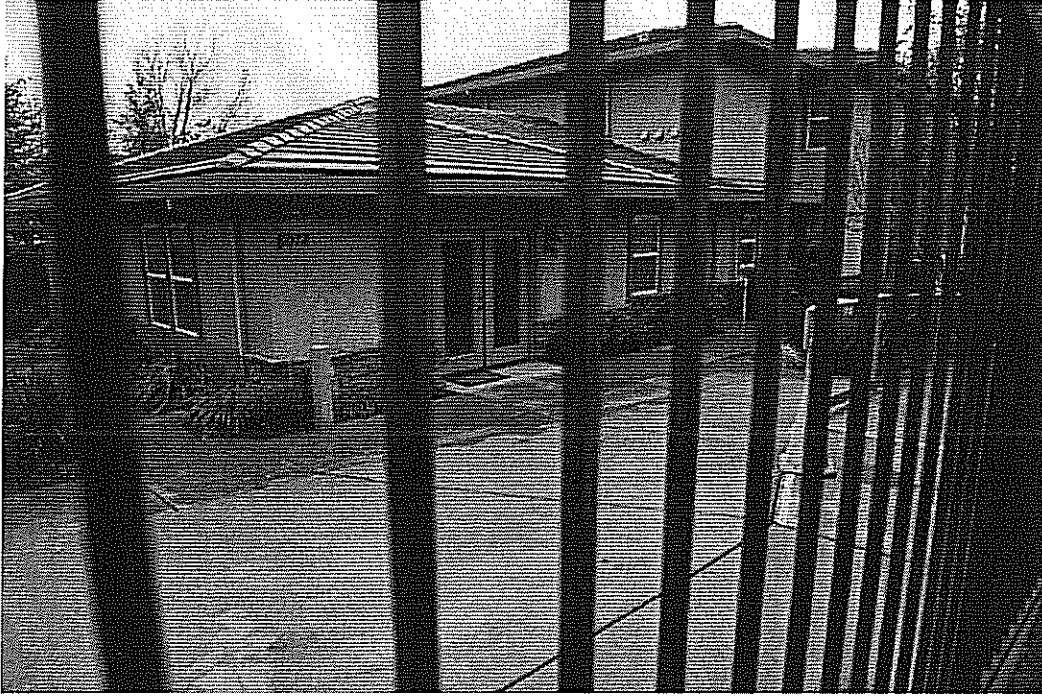


Audit: California nursing home oversight haphazard

HIGHLIGHTS

The California Department of Public Health is stumbling in its oversight of nursing homes and other long-term care facilities, weighed down by a backlog of more than 11,000 open complaints – and no clear path to dig its way out, the California state auditor has concluded.



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The California Department of Public Health is stumbling in its oversight of nursing homes and other long-term care facilities, weighed down by a backlog of more than 11,000 open complaints – and no clear path to dig its way out, the California state auditor has concluded.

The widely anticipated report, released Thursday, details how the department has failed to effectively manage investigations of complaints related to long-term care in California. The auditor detailed problems up and down the state, where district offices were found to be inconsistent and haphazard in their handling of complaints, investigations and corrective action plans.

The open complaints were not trivial. The auditor found that 40 percent of the unresolved concerns and allegations had been given high priority by the department, meaning that the reported problem had caused or was likely to cause harm to a resident.

In one case, for instance, the state received a complaint in April 2012 about a certified nurse assistant allegedly slapping a resident, actions that “constitute abuse,” according to the audit. However, the state did not assign staff to investigate the complaint until August 2013 – about 16 months later – when the resident, the only witness, had already left the facility. The case was closed with a warning to the nurse assistant.

In the report, department officials acknowledged problems and agreed with many of the auditor’s recommendations. But they pushed back at the recommendation that the department establish specific time frames for completing investigations of complaints. The department’s response offers no explanation for why it rejects the timeline recommendation, but says it “recognizes the importance of timeliness.”

The state’s response was signed by Kathleen Billingsly, the department’s No. 2, on behalf of Director Dr. Ron Chapman.

“It’s a scathing report, really,” said Carole Herman, president of the Sacramento-based Foundation Aiding the Elderly. “The system is in place, but it’s not functioning.”

“And no one who is high up in the agency is being held accountable for it,” said Herman, who routinely files complaints with the state on behalf of nursing home residents and their families.

Last year, Herman and her nonprofit group sued the department, alleging it was endangering vulnerable residents by failing to promptly investigate nursing home complaints. The suit, pending in San Francisco Superior Court, accuses state regulators of “taking months and sometimes years” to complete investigations of nursing homes and other long-term care facilities.

The state auditor also documented long delays. For instance, three complaints that were not deemed high priority remained open in one district office for an average of 3,500 days, or nearly 10 years.

The Department of Public Health is responsible for licensing and monitoring certain health care facilities, including more than 2,500 long-term facilities serving as many as 300,000 Californians. About half of those facilities are nursing homes.

In a prepared statement, the California Department of Public Health said: “We appreciate the opportunity to improve our operation. Our response to the audit is contained in the report, and we will be reporting our progress to the auditor.”

Deborah Pacyna, spokeswoman for the California Association of Health Facilities, an industry group, said her organization supported the auditor’s findings.

“We agree with the auditor’s findings; there should be a timely review of complaints,” Pacyna said. “Specifically, it should not take any longer than 60 days to investigate and resolve a complaint. If there’s an issue, our members want to know about it and fix the problem. If the department needs more money or staff to do their job, they should get those resources.”

The auditor’s report was requested earlier this year by Assemblywoman Mariko Yamada, D-Davis, chair of the Aging and Long-Term Care Committee. Yamada and Democratic Assemblyman Richard Pan led a joint oversight hearing in January to examine allegations that complaints of abuse and misconduct were piling up at the department, and that investigations were being opened and closed indiscriminately.

Among many recommendations, the auditor urged the department to create a system to improve its tracking of complaints; establish clear time frames for completing investigations; give district offices consistent guidance; and increase monitoring of the district offices’ compliance with laws and policies.

“There just appears to be sort of a culture of indifference in the department,” said Yamada, a former social worker and civil rights investigator.

“I don’t know that I could sleep, knowing that there was such a backlog, without going in to try to advocate for some of our state’s poorest and most frail residents.”

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