California State Auditor FACT SHEET

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The California State Auditor released the following report today:

Developmental Centers

Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk

BACKGROUND

Approximately 1,600 Californians with developmental disabilities reside in and receive medical and other services from one of the California Department of Developmental Services' (department) developmental centers. Each center develops and maintains policies for identifying and preventing abuse and neglect of residents. Officers from the department's law enforcement division, the Office of Protective Services (OPS), are on-site at each center and respond to alleged abuse of residents. The California Department of Public Health (Public Health) licenses and certifies the centers as skilled nursing facilities, intermediate care facilities, and general acute health care hospitals. Public Health conducts site visits for required inspections, called surveys, of licensed facilities at each center and investigates complaints involving those facilities.

KEY FINDINGS

During our review of resident safety at the department's developmental centers, we noted the following:

- Health care staff did not always promptly notify OPS staff that an incident had occurred—in seven of 60 health care reviews we examined, staff took from two and a half hours to nine days to notify OPS.
- The quality of OPS's investigative work frequently fell short of its standards, and investigations were not always completed timely. We found, in the 48 OPS investigations we reviewed, that:
  - ✓ OPS often failed to collect the required evidence during its investigations: OPS did not obtain written declarations from witnesses and the subjects of investigations in 21 cases, did not photograph alleged victims' injuries in 19 cases, and did not obtain specialized medical examinations for alleged victims of sexual assault in two cases.
  - ✓ OPS completed only 24 investigations (or 50 percent) within 30 days with three taking 292, 436, and 585 days, respectively, to complete.
- The same investigator conducted both the criminal and administrative investigations in eight cases, even though a 2002 report by the Office of the Attorney General stated that when an incident has both criminal and administrative implications, two separate investigators should conduct separate investigations.
- The department has not addressed longstanding problems, many of which were raised in the 2002 report.
  - ✓ In the last 10 years, the OPS chief has transitioned six times and the commander in each of the developmental centers have transitioned between eight and 10 times.
  - ✓ The department has not provided sufficient specialized training to its law enforcement staff.
  - ✓ Even though OPS has suffered high vacancy rates, the department has no formal recruitment process—in fiscal year 2011-12, OPS had a vacancy rate of 42.8 percent in its law enforcement positions.
  - ✓ Developmental centers have allowed some employees to work excessive amounts of overtime. Sixty-two health care and OPS law enforcement employees doubled their pay during a five-year period–they were paid nearly $14.1 million in overtime pay and $11.4 million in regular pay.
- While Public Health has conducted most of the federal certification surveys on time for the developmental centers, it did not complete nearly 60 percent of the required state licensing surveys for fiscal years 2005-06 through 2011-12.
- Although Public Health promptly investigated developmental center incidents classified as most serious, we found significant variation in the time it took to initiate investigations for incidents considered to have lower priority.

KEY RECOMMENDATIONS

We made recommendations to the department including that it amend policies and procedures for how OPS conducts investigations and that OPS provide the appropriate specialized training to its law enforcement staff. We also recommended that it promptly address OPS's high number of vacancies, institute a formal recruitment program, and reassess staffing requirements to minimize the need for overtime. Further, to make certain that residents receive an adequate level of care and are protected from harm, the department should monitor closely the overtime approval process, attempt to cap the number of voluntary overtime hours employees can work, and distribute the overtime more evenly among staff.

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