



Board of Registered Nursing

Executives Violated State Law When They Falsified Data
to Deceive the State Auditor's Office

June 2020

INVESTIGATIVE REPORT I2020-0027





CALIFORNIA STATE AUDITOR

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June 30, 2020
Investigative Report I2020-0027

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

The California State Auditor (State Auditor), as authorized by the California Whistleblower Protection Act, conducted an investigation into allegations that executives within the Board of Registered Nursing (BRN) intentionally manipulated data and delivered a falsified report to my office in 2018 to satisfy a recommendation we had made during a 2016 audit of BRN's enforcement program.

The investigation substantiated that BRN executives violated state law when they carried out a plan to artificially decrease caseloads for BRN investigators before delivering a falsified report to my office. The plan involved temporarily reassigning some of BRN investigators' cases to other employees who should not have had the cases assigned to them. Within 10 days of my office reviewing the falsified report and concluding that BRN had fully implemented the audit recommendation, BRN managers reversed the reassignments, which increased caseloads to their original levels. The executives' deceitful actions obstructed our required follow-up to the audit recommendation and constituted gross misconduct.

The executives' behavior also undermined the trust that our office had with BRN. When we received the whistleblower complaint that precipitated this investigation, we were midway through fieldwork for a separate audit of BRN's oversight of precicensure nursing school programs, audit 2019-120, which we anticipate publishing in July 2020. Consequently, that audit team closely reviewed the data it obtained from BRN and confirmed the reliability of the evidence the auditors used in readying their findings and recommendations for the forthcoming audit report.

We recommend that BRN take appropriate corrective action against the executives involved and that it take steps to address investigator caseloads and fully implement the recommendation from the 2016 audit. BRN must report to my office any corrective or disciplinary action it takes in response to recommendations we have made. Its first report is due August 12, 2020, which is 60 days after we notified it of the improper activity. It must continue to report monthly thereafter until it has completed corrective action.

Respectfully submitted,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA
California State Auditor

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Investigative Results

Results in Brief

After we received a whistleblower complaint alleging that Board of Registered Nursing (BRN) executives intentionally manipulated the data used to create a report, we initiated an investigation and found that three executives at BRN conceived and carried out a plan in late 2018 to manipulate data and provide a deliberately misleading report to the California State Auditor (State Auditor). The report falsely showed that BRN had decreased its investigators' caseloads enough to satisfy a recommendation the State Auditor had made to BRN in an audit report titled *Board of Registered Nursing: Significant Delays and Inadequate Oversight of the Complaint Resolution Process Have Allowed Some Nurses Who May Pose a Risk to Patient Safety to Continue Practicing*, 2016-046, December 2016.

Furthermore, our investigation revealed that one of those executives directed his subordinate managers to carry out the plan to deliberately change the caseload distribution information. Specifically, in November 2018, as the executive prepared documentation for the State Auditor's required follow-up to the 2016 audit recommendations, he directed two managers to reassign cases within BRN's case tracking system so that a caseload report would indicate that each BRN investigator had a caseload of 20 or fewer investigations. This threshold was based on statements by BRN's chief of investigations during the 2016 audit that a full caseload for BRN's investigators was 20 cases.

Knowing that the data misrepresented BRN investigators' actual caseloads, one of the BRN executives submitted the falsified report to the State Auditor's Office with the intent of convincing the State Auditor that it had fully implemented the recommendation. As BRN executives anticipated, the State Auditor's audit team (audit team) relied on BRN's manipulated data and declared the recommendation to have been fully implemented. The executives' actions obstructed the State Auditor from making a correct assessment regarding the status of the audit recommendation. The executives also demonstrated dishonesty by intentionally misrepresenting known facts, and their misdeeds brought discredit to BRN. The serious and egregious nature of the executives' overall behavior regarding this matter constituted gross misconduct.

Relevant Criteria

Government Code section 8545.6 states that any officer or employee who, with intent to deceive or defraud, obstructs the California State Auditor in the performance of his or her official duties relating to a statutorily required audit is subject to a fine not to exceed five thousand dollars (\$5,000).

Government Code section 8547.2 provides that an improper governmental activity includes actions of gross misconduct undertaken by any state employee in the performance of the employee's duties. In general, gross misconduct is unacceptable behavior of the sort that typically results in dismissal of the offending employee.

Government Code section 19572 specifies that employee dishonesty constitutes a cause for discipline, and an employee who engages in "other failure of good behavior that causes discredit to the employee's agency or employment" is also subject to discipline.

Background

BRN is responsible for implementing and enforcing the Nursing Practice Act, which establishes the laws related to the licensure, practice, and discipline of nurses. In its mission to protect the public, BRN regulates more than 430,000 licensed nurses who provide health care services to the public. It receives an average of about 8,500 complaints annually regarding licensed nurses and prospective nurse applicants.

To help ensure that BRN fulfills its mission and legal obligations, the State enacted a statute in 2015 that required the State Auditor to conduct an audit of BRN. In December 2016, the State Auditor's Office published report 2016-046, *Board of Registered Nursing: Significant Delays and Inadequate Oversight of the Complaint Resolution Process Have Allowed Some Nurses Who May Pose a Risk to Patient Safety to Continue Practicing*, which summarized the mandatory audit it conducted of BRN's enforcement program. In particular, the audit team found that BRN consistently failed to process complaints within the 18-month goal that its oversight agency, the Department of Consumer Affairs, had established. This failure to process complaints in a timely manner contributed to a backlog of more than 180 complaints against registered nurses as of July 2016. The audit team concluded that unnecessary delays in the complaint resolution process enabled nurses who were the subject of serious allegations to continue practicing and may have posed a risk to patient safety.

To enhance public safety, the State Auditor's report made several recommendations to BRN, including that it establish a plan to eliminate its backlog of complaints awaiting assignment to a BRN investigator. In BRN's required 60-day response to the audit, BRN claimed to have eliminated the backlog of cases, in part, by increasing the number of cases it assigned to its investigators from 20 to 25. However, the audit team concluded that this approach did not fully satisfy the recommendation because BRN's chief of investigations had confirmed during the initial audit that a full caseload for BRN's investigators was 20 cases. Therefore, the audit team determined that BRN had simply shifted—not eliminated—its backlog of complaints and that BRN had not yet fully implemented this recommendation. For the next year and a half, BRN continued to claim that it had fully implemented the recommendation, but because BRN never provided evidence that it had reduced investigator caseloads, the audit team did not agree.

State law compels the State Auditor to solicit responses from statutorily audited entities within 60 days, six months, and one year of an audit report's publication and annually thereafter until the audit team determines that each recommendation has

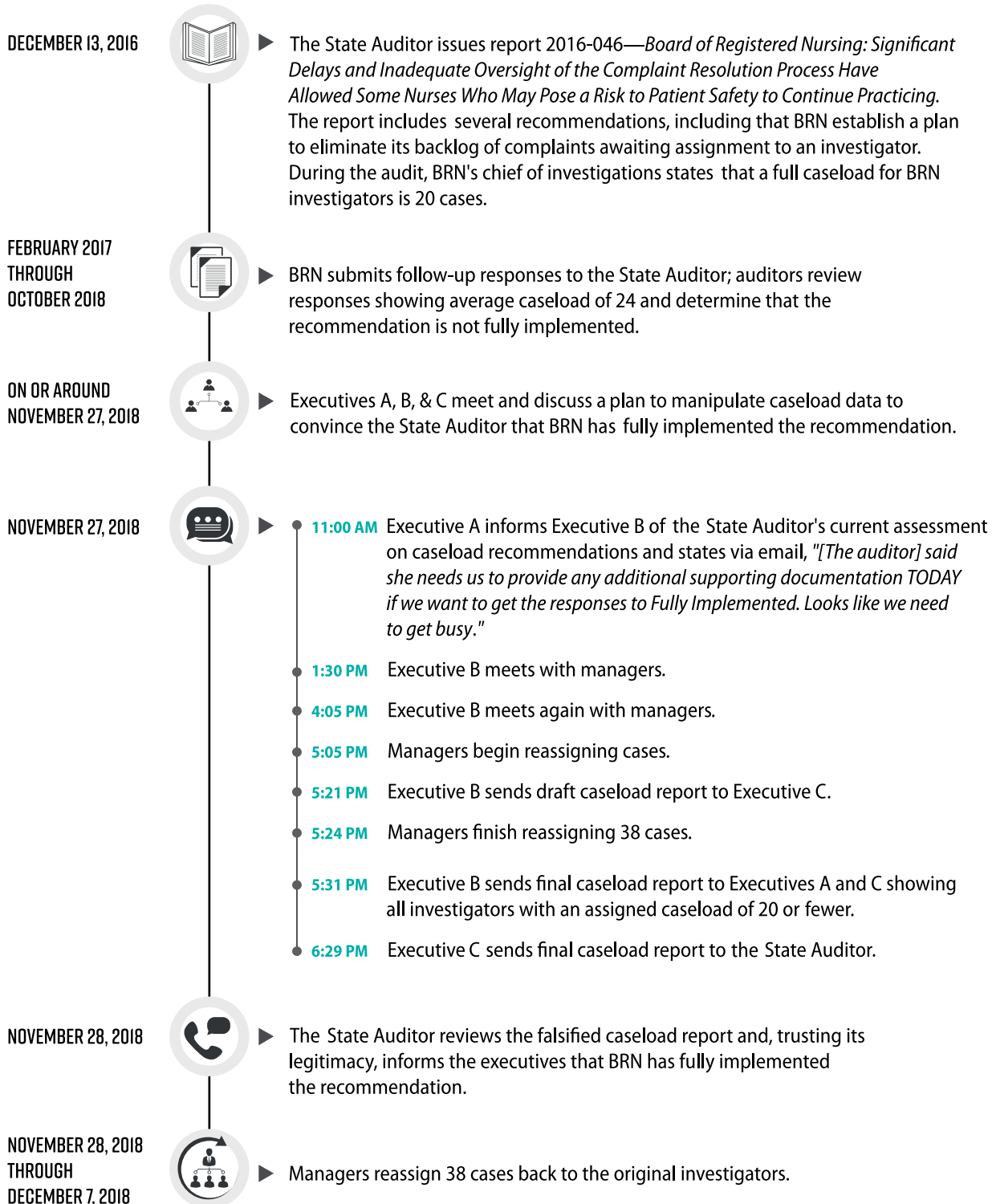
been fully implemented. Furthermore, the State Auditor must report to the Legislature the progress on any recommendations that agencies have not fully implemented within one year. In order to verify that an audited entity has fully implemented a recommendation, the State Auditor relies not only on the entity's claims, but it also requires that the entity supply the necessary data and documentation to substantiate any claims of progress or completion.

In its November 2018 annual update about progress toward implementing recommendations, BRN provided the caseload report that is the subject of this investigation and that demonstrated investigator caseloads of 20 or fewer for each member of its investigative team. The audit team reviewed the report and concluded that BRN had fully implemented the recommendation. As a result, the State Auditor's January 2019 report to the Legislature, *Recommendations Not Fully Implemented After One Year: The Omnibus Audit Accountability Act of 2006*, report 2018-041, reflected that BRN had fully implemented the recommendation in question from the original 2016 audit.

Executives Intentionally Manipulated Investigator Caseload Data Before Providing a Report to the State Auditor

The investigation revealed that three BRN executives devised a plan to manipulate BRN's investigator caseload data to convince the State Auditor that it had fully implemented the recommendation from the 2016 audit about clearing its backlog of outstanding complaints. In November 2018, the State Auditor's Office reminded BRN that its annual update about its progress toward implementing recommendations from the 2016 audit would be due by the 27th of that month. When we interviewed Executive B and Executive C, they confirmed that they met with Executive A and discussed a plan to temporarily reassign investigations from investigators who carried more than 20 cases to managers and another employee who did not carry a caseload at the time. Executive B stated that other executives and managers were also present at this meeting as well. The plan involved producing a report for the audit team that showed that all investigators had a caseload of 20 or fewer and then shortly thereafter reshuffling the cases back to the original investigators. Figure 1 provides a timeline that describes when and how BRN executives carried out this plan.

The plan to deceive the State Auditor involved producing a report for the audit team that showed that all investigators had a caseload of 20 or fewer and then shortly thereafter reshuffling the cases back to the original investigators.

Figure 1**Timeline of Events Leading Up to Submission of Falsified Caseload Report**

Executive B acknowledged that, following the meeting with Executives A and C, he put the plan into action. On the afternoon of November 27, 2018—the due date for providing an update to the State Auditor—he met with two managers who reported to him. They discussed the plan and he directed them to begin reassigning cases in BRN’s case tracking system. Then, shortly after 5 p.m., the managers engaged in what they later described to us as a hurried process of reassigning a total of 38 cases, sometimes reassigning cases multiple times, so that no investigator’s individual caseload exceeded 20 cases. To accomplish the goal of 20 cases or fewer per investigator, the managers reassigned 20 cases to one BRN investigator who was out on extended leave and was not anticipated to be back for more than a month. They also temporarily reassigned cases to one of the managers, even though managers do not typically carry their own caseloads. Shortly before 5:30 p.m., the managers finished the task and notified Executive B, who had been updating Executive A and Executive C on the reassignments. At some point, the managers notified BRN’s investigators that some of their cases would be or had been temporarily reassigned, but that they were still responsible for them.

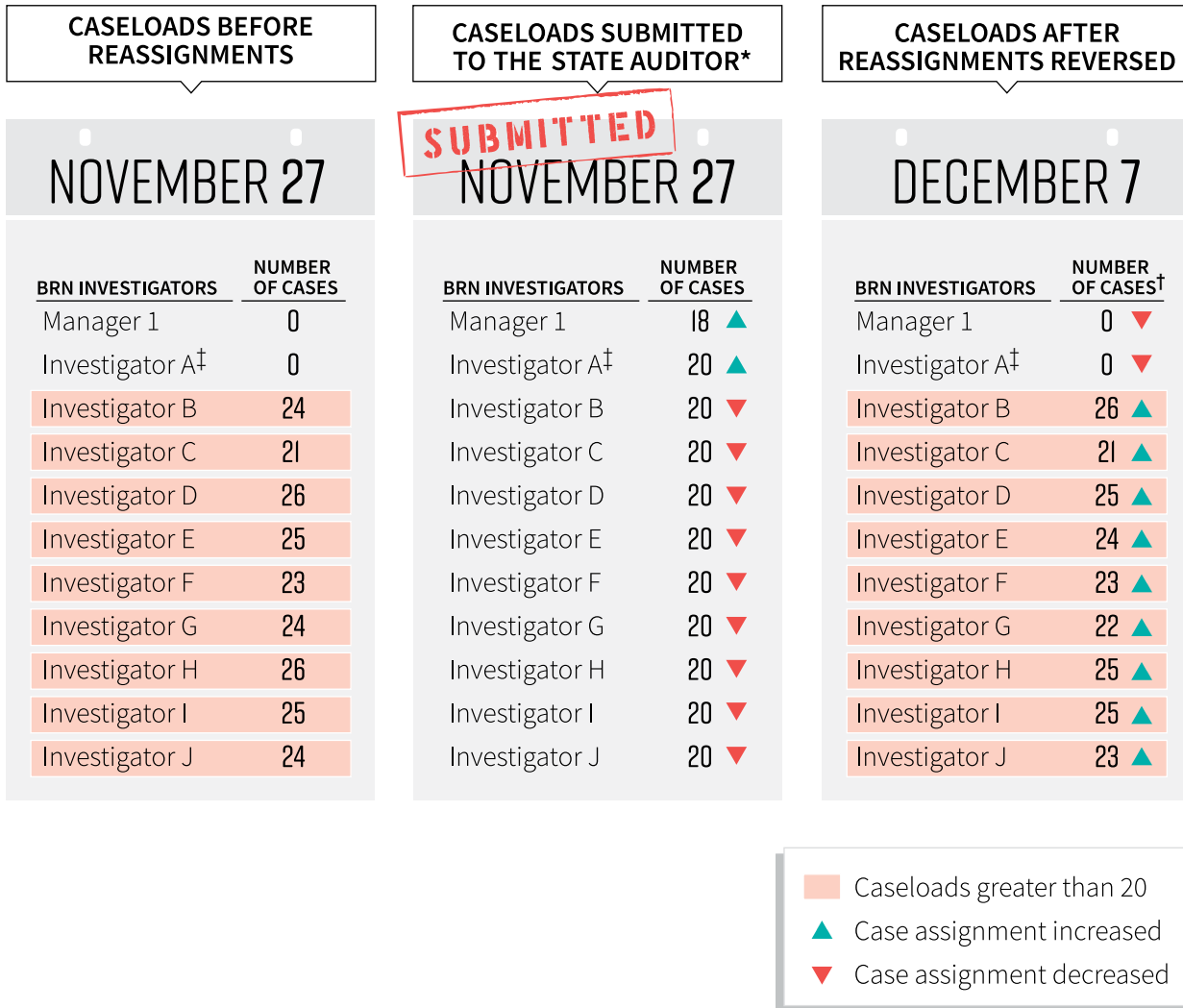
Although the two managers certainly played a key role in producing the manipulated report, their actions appear to have been at the direction of Executive B. Both managers acknowledged that the numbers in the caseload report were either “fudged” or “inaccurate” and that they either knew or assumed the report was intended for the State Auditor. They claimed to have objected to the plan and only proceeded after Executive B disregarded their concerns and provided a clear directive to move forward with the plan.

Once the managers finished their task, Executive B emailed to Executive C and Executive A the caseload report showing all investigators with caseloads of 20 or fewer. Executive C reviewed the documentation and an hour later emailed the caseload report, along with documentation related to other recommendations, to a member of the audit team.

The next day on November 28, the audit team reviewed the report—which it assumed was legitimate and truthful—and informed the executives that it would now credit BRN with having fully implemented the recommendation. That same day, the managers at BRN began reversing many of the assignments they had made fewer than 24 hours earlier to assist the executives with the falsified report for the State Auditor. Within 10 days of making the initial changes, the managers had reassigned all 38 cases back to the original investigators, and many had, yet again, caseloads in excess of 20 cases. Figure 2 demonstrates how managers shifted cases during the 10-day span in question. Since November 2018, many BRN investigators have continued to carry caseloads of as many as 26 cases.

Both managers acknowledged that the numbers in the caseload report were either “fudged” or “inaccurate” and that they either knew or assumed the report was intended for the State Auditor.

Figure 2
Comparison of Caseload Report Manipulation



Source: Analysis of BRN’s case tracking system data.

* Figure 2 displays a selection of the caseloads included in the report BRN submitted to the State Auditor.

† The managers reassigned the cases back to the original investigators between November 28, 2018, and December 7, 2018. During this time period, BRN closed some of the investigators’ cases and managers assigned new cases to some investigators, which affected their caseload totals.

‡ Investigator A was out on extended leave during this time.

The Executives' Obstruction Violated State Law and Constituted Gross Misconduct

The investigation revealed that the executives sought to deliberately obstruct the State Auditor from making an accurate determination of BRN's implementation of the recommendation, and that they achieved that obstruction with dishonest behavior. Both of these actions are violations of state law and, together, brought discredit to BRN and constituted gross misconduct.

When interviewed, both Executive B and Executive C admitted that they knew the caseload report they prepared and provided to the State Auditor was not an accurate reflection of the investigators' workloads. They also both acknowledged that the intent behind their plan was to appease the audit team so it would conclude that BRN had fully implemented the recommendation. They both expressed regret for having participated in the plan and said that they knew it was problematic or not the right approach. We were unable to interview Executive A, who is no longer employed by BRN, but the other executives credibly described that Executive A either came up with the idea to reassign cases or pushed to implement the plan. Executive B explained how he had one-on-one conversations with Executive A to provide updates about how the case reassignments were progressing.

All three executives' actions to intentionally send false data to the audit team obstructed the State Auditor from making an accurate determination of BRN's progress in implementing the recommendation—an official duty imposed on the State Auditor by state law. Therefore, in accordance with the law, the State Auditor will seek to impose a fine not to exceed \$5,000 on each of the executives involved.

Taken as a whole, the executives' behavior that led to and included the submission of the falsified report constituted gross misconduct: they violated several laws, including the obstruction statute, by presenting intentionally manipulated data to deceive the State Auditor—and ultimately the Legislature. Such deceit demonstrates dishonesty and a lack of integrity, and not only undermines the State Auditor's trust in the agency, but also brings discredit to BRN as a whole. For those reasons, the executives are subject to discipline for dishonesty and "other failure of good behavior."

During our investigation, we did not uncover any evidence that the executives provided any other false, incomplete, or inaccurate information with respect to the other 2016 audit recommendations. However, due to the nature of the misconduct

All three executives' actions to intentionally send false data to the audit team obstructed the State Auditor from making an accurate determination of BRN's progress in implementing the recommendation.

we discovered, the State Auditor will likely have to spend additional resources on future engagements with BRN to mitigate the risk that BRN might provide further incomplete or inaccurate information.

Recommendations

To remedy the effects of the improper governmental activities identified by this investigation and to prevent those activities from recurring, we recommend that BRN take the following actions:

- Within 90 days, take appropriate corrective action against Executives B and C, and consider placing a notice of the investigation in Executive A's personnel file, as that individual has left BRN.
- Within 30 days, reassess investigator caseloads and determine the maximum number of cases that investigators should be assigned based on clear criteria.
- Within 90 days, work with the audit team to develop a satisfactory approach for fully implementing the 2016 audit recommendation.

Summary of Agency Response

BRN stated that it takes the investigative findings and recommendations very seriously. It informed us that it initiated its own investigation and will take the appropriate corrective action based on the results of its investigation and that it plans to place a notice of the investigation in Executive A's personnel file. It also stated that it will begin reassessing investigator caseloads and establishing clear criteria for the maximum number of cases that investigators should be assigned. Finally, it is committed to working with the audit team to develop a satisfactory approach for fully implementing the audit recommendation.

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

June 30, 2020