California State Auditor

July 2013

Developmental Centers

Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk

Report 2012-107

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California State Auditor

Elaine M. Howle State Auditor
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July 9, 2013 2012-107

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

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning resident safety at developmental centers operated by the California Department of Developmental Services (department).

This report concludes that the department needs to improve its oversight of the safety of residents housed and cared for in its developmental centers. Our review found that health care staff did not always provide timely notification of incidents to the department's Office of Protective Services (OPS), and that OPS law enforcement personnel did not consistently follow established procedures for investigations of alleged resident abuse. Specifically, OPS often failed to collect written declarations from suspects and witnesses, take photographs of crime scenes or alleged victims, and attempt to interview alleged victims, particularly residents said to be nonverbal.

Frequent turnover in OPS management has contributed to a lack of action in addressing longstanding problems, many of which were raised in a 2002 Office of the Attorney General's report. These problems include a lack of required specialized training for OPS personnel to effectively work with residents, high vacancy rates within OPS, and OPS's lack of a cohesive recruiting plan. Furthermore, both OPS and the department's health care staff have experienced excessively high amounts of overtime, caused by staff scheduling issues and hiring freezes.

Finally, our review of the California Department of Public Health's (Public Health) oversight responsibilities has shown that it does not consistently perform all of its required duties, such as promptly performing follow-ups on certification surveys and performing state licensing surveys on time, if at all. Public Health also does not consistently conduct prompt investigations for incidents it classifies as less serious. Furthermore, because Public Health has not prepared required annual reports regarding its enforcement activities, the effectiveness of these activities on maintaining quality of care in health care facilities, including the developmental centers, remains uncertain.

Respectfully submitted,

DOUG CORDINER, CGFM
Chief Deputy State Auditor

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Contents

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Summary

Results in Brief

The California Department of Developmental Services (department) needs to improve its oversight of resident safety in its developmental centers. The department is responsible for operating state-owned developmental centers, which house and care for individuals with significant developmental disabilities (residents). Developmental centers are staffed with nurses, psychiatric technicians, and other health care professionals who support the ongoing health and safety of the residents who live there. When health care staff discover that a resident has experienced an injury or inappropriate risk of harm, they must report the incident and also initiate a review of the circumstances. Although the department's health care staff generally perform these reviews according to appropriate procedure, they do not always provide timely notification to the department's Office of Protective Services (OPS). OPS law enforcement officers are on-site at each developmental center and, in addition to general patrol and traffic enforcement duties, respond to alleged abuse of residents. However, OPS does not appear to routinely follow its established procedures for investigations of alleged abuse.

We reviewed 48 OPS investigations and found 54 deficiencies in 267 applicable observations. In particular, OPS often did not collect written declarations from witnesses and suspects during incident investigations, often did not take photographs of crime scenes or alleged victims, and did not always attempt to interview alleged victims, particularly residents who were said to be nonverbal. These deficiencies cast doubt on OPS's quality assurance process, which includes supervisory reviews, and cause the department to have less assurance that its OPS investigation conclusions are correct. Investigative deficiencies, such as those we observed, may allow for continued abuse at the developmental centers.

Partially as a result of frequent turnover in OPS management, the department has struggled to address longstanding resident safety issues, including updating outdated and underdeveloped OPS policies and oversight practices. The department hired law enforcement consultants in early 2012 to help it update OPS policies to strengthen areas of noncompliance and to add other best practices. As of May 2013 the department was preparing to finalize and implement the policy updates. One ongoing, unaddressed concern is the training and hiring of OPS personnel. Although OPS complies with minimum requirements concerning qualifications and training, it has not required the specialized training OPS personnel need to effectively work with residents, such as training in nonverbal communication skills. Another continuing

Audit Highlights . . .

Our audit on resident safety at the California Department of Developmental Services' (department) developmental centers highlighted the following:

- *The department's health care staff do not always provide timely notification of incidents to its Office of Protective Services (OPS).*
- *OPS did not routinely follow its investigation procedures of alleged resident abuse.*
  - *It frequently failed to collect written declarations from witnesses and suspects during incident investigations.*
  - *It often did not take photographs of crime scenes or alleged victims.*
  - *It did not always attempt to interview alleged victims, particularly those who were said to be nonverbal.*
- *Lack of continuity in OPS's leadership has contributed to the department's inability to address longstanding resident safety issues.*
  - *The department does not regularly provide specialized training for OPS staff to work with residents.*
  - *The department lacks a formal recruitment program to address the high vacancy rates within OPS and counteract its lower salaries compared to those of nearby local law enforcement entities.*
- *Both OPS and health care staff have worked excessive overtime, which could compromise the safety of staff and residents.*

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» *The California Department of Public Health (Public Health) has not consistently performed all of its required duties when overseeing the developmental centers.*

- *Its follow up on certification surveys was not always performed promptly.*
- *It frequently failed to perform state licensing surveys.*
- *It did not consistently initiate timely investigations for incidents it classifies as less serious.*
- *It has not prepared required annual reports evaluating the effectiveness of its enforcement activities.*

challenge for OPS is the hiring and retention of qualified staff. One impediment is that OPS salaries are lower than those of the local law enforcement entities with which the developmental centers compete for employees. Even so, OPS has not developed a cohesive recruiting approach to attempt to counteract this disparity.

One potential consequence of its difficulties in hiring may be OPS's vacancy rate of roughly 43 percent, causing—at least partially—its high levels of overtime. Likewise, certain health care positions within the department, its psychiatric technicians in particular, have experienced high levels of overtime. In fact, we identified 62 department employees who worked so many extra hours that their overtime pay equaled or exceeded their regular pay over a five-year period. The department indicated that these staff and others who have worked significant overtime have done so out of necessity created by vacancies and other staffing issues caused by long periods of statewide budget reductions and corresponding hiring freezes. Nevertheless, research studies indicate that excessive overtime causes fatigue in health care staff and peace officers, and this fatigue can result in mistakes that put residents at risk of harm.

We noted that, although OPS overtime pay still appears to be excessive at 23 percent of regular pay in 2012, the department has reduced OPS overtime over the last three years and is now tracking the amount of overtime OPS employees work. However, another important performance measure—tracking outstanding investigative cases—was put on hold for a time as the result of OPS management turnover.

Despite a recommendation made more than 10 years ago by law enforcement consultants, the department has not created measurable short- and long-term goals for OPS. In Appendix A we list recommendations from a 2002 report by law enforcement consultants hired by the Office of the Attorney General. The lack of action to implement some of these recommendations has led to systemic issues, such as excessive OPS overtime and inconsistent implementation of practices and procedures, inappropriately putting developmental center residents at risk.

The California Department of Public Health (Public Health), which provides oversight of the developmental centers, has not consistently performed all of its required duties. We found that Public Health has failed to consistently perform prompt follow-ups on certification surveys or to perform state licensing surveys on time or at all. In addition, Public Health does not promptly perform investigations for incidents it classifies as less serious. Finally, because Public Health has not prepared a required report, the effectiveness of its enforcement practices, particularly those related to developmental centers, remains uncertain.

Recommendations

The department should provide a reminder to staff about the importance of promptly notifying OPS of incidents involving resident safety.

To provide adequate guidance to OPS personnel, the department and OPS should place a high priority on completing and implementing the planned updates to the OPS policy and procedure manual.

To help ensure the quality of OPS investigations, the department should revise its OPS training policy to require its law enforcement personnel to annually attend specialized trainings that address their specific needs. At least initially, the department should focus the additional trainings on communicating with residents, writing effective investigative reports, and collecting investigative evidence.

After the department has implemented a formal OPS recruiting program, if it can demonstrate that it is still unable to fill its vacant OPS positions, the department should evaluate how it can reduce some of the compensation disparity between OPS and the local law enforcement agencies with which it competes for qualified personnel.

To minimize the need for overtime, the department should reassess its minimum staffing requirements, hire a sufficient number of employees to cover those requirements, and examine its employee scheduling processes.

To improve its enforcement, each year Public Health should evaluate the effectiveness of its enforcement system across all types of health facilities, including those in developmental centers, and prepare the required annual report to the Legislature.

Agency Comments

The department concurred with our findings and recommendations and supports the recommendations to strengthen areas that further increase protections and reduce risk to developmental center residents. The department stated that many of the recommendations have already been implemented or are underway. Public Health agreed with all but one of our recommendations and indicated that it is in the process of implementing them. Public Health disagrees with our recommendation that it should develop and implement target time frames for investigation priority levels that lack them because it believes its current process is sufficient to assign and monitor timeliness.

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Introduction

Background

Approximately 1,600 Californians with developmental disabilities reside in state-operated facilities called developmental centers. In addition to providing housing and medical services, developmental centers provide training and treatment to disabled residents for the purpose of increasing their levels of independence and functioning skills. The California Department of Developmental Services (department) operates and administers the developmental centers. The California Department of Public Health (Public Health) licenses and certifies the developmental centers, which the State recognizes as hospitals and nursing facilities and which receive Medicaid funds for some services they provide.

Departmental Organization

Developmental centers are part of the department's statewide network of services for Californians with developmental disabilities. This population, who the department calls consumers, includes developmental center residents (residents) and individuals living in less-restrictive community settings. The department provides support services through the State's 21 nonprofit regional centers, which coordinate services for all consumers. If a regional center determines that a consumer needs to be placed at a developmental center and a court agrees, the consumer will be admitted to a center as a resident.[1] After an individual's initial intake into a developmental center, federal regulations require facilities to prepare a plan of activities and treatment for the resident. The department satisfies this requirement by preparing an individual program plan (IPP) for each developmental center resident. This plan outlines the services the resident will receive and the professionals who will provide the services.

The developmental centers are licensed and certified as skilled nursing facilities, intermediate care facilities for the developmentally disabled (intermediate care facilities), and general acute health care hospitals. They are staffed with nurses, psychiatric technicians, and other health care professionals who support the

[1] While this system remains in place, legislation signed into law in 2012 has restricted new admissions to developmental centers. Under this new law, only those who are in acute crisis or who are incompetent to stand trial as determined by a court may be admitted to the developmental centers.

ongoing health and safety of the residents who live there and who ensure that the residents receive the services listed in the IPP. The department currently operates four centers:

- Fairview Developmental Center, located in Costa Mesa
- Lanterman Developmental Center, located in Pomona
- Porterville Developmental Center, located in Tulare County
- Sonoma Developmental Center, located in Eldridge

In addition, the department operates a smaller community facility in Cathedral City called Canyon Springs Community Facility.[2]

Federal and state funds provide for the developmental centers' ongoing operations. According to the Legislative Analyst's Office, the State budgeted $550 million for the developmental centers in fiscal year 2012–13—an average of about $340,000 per center resident. The majority of funds for the centers come from two sources: the State's General Fund, from which $286 million was budgeted, and federal Medi-Cal reimbursements, anticipated to be $248 million. The $550 million budgeted for fiscal year 2012–13 represents a 5 percent decrease from the $577 million the State spent on developmental centers in fiscal year 2011–12.

Use of Developmental Centers Is Decreasing

In state law, California has accepted responsibility for Californians with developmental disabilities. The Lanterman Developmental Disabilities Services Act (Lanterman Act) and related laws provide a framework for ensuring the health and safety of individuals with developmental disabilities. The Lanterman Act defines developmental disabilities as including cerebral palsy, epilepsy, autism, and conditions associated with intellectual disability that originated before the person turned 18 years old and can be expected to continue indefinitely. All residents of developmental centers have at least one developmental disability.

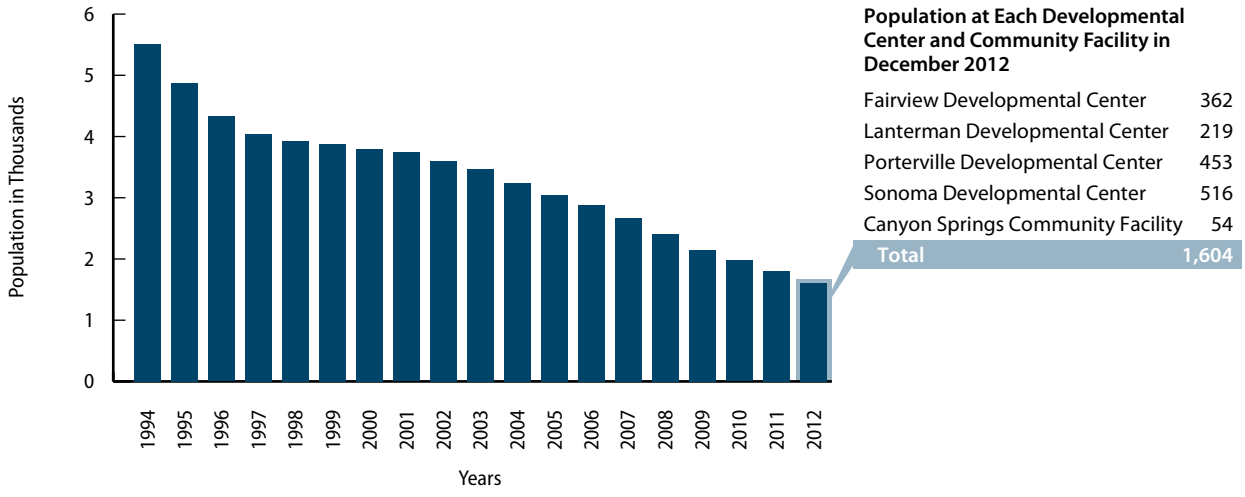
However, not all individuals with developmental disabilities need to reside in these facilities. In fact, many developmental center residents have found that with the right forms of support, they can leave the centers and live in their communities. In fact, the Lanterman Act codified the State's policy preference for consumers

[2] The department closed a fifth developmental center, Agnews Developmental Center in San Jose, in 2009. In 2010 it closed Sierra Vista, a community facility in Yuba City.

to live in their communities, in the least restrictive environment possible. The movement toward this policy was strengthened by a 1999 U.S. Supreme Court decision[3], which declared that persons with mental disabilities should be placed in community settings rather than in institutions when treatment professionals have determined that community placement is appropriate, the individual does not oppose transfer from institutional care to a less restrictive setting, and the placement can be reasonably accommodated with resources available to the State. Five years prior to this decision, California began a program to move residents out of developmental centers and into their communities if appropriate housing and supports were available.

Department data show that developmental center population has been in a decades-long decline. At the end of 1994, the total population of developmental center residents was roughly 5,500, and it has since declined to just over 1,600, as shown in Figure 1. Because recent legislation limits new admissions to the developmental centers to consumers who either are in an acute crisis or are found by a court to be incompetent to stand trial, the developmental center population will likely continue to decrease.

Figure 1
Population of Residents in Developmental Centers
1994 Through 2012



Source: California Department of Developmental Services' Web site as of March 2013.

[3] *Olmstead v. L.C.* (1999) 527 U.S. 581.

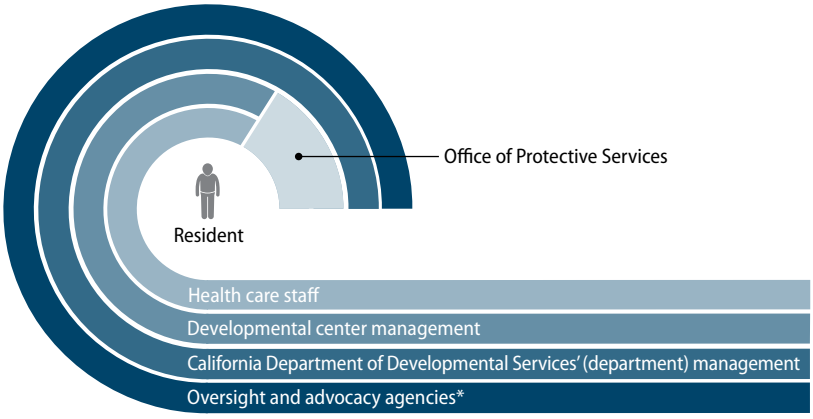
Safety at the Developmental Centers

Federal regulations, state law, and department policies forbid abuse and neglect of developmental center residents. Physical abuse, sexual abuse, verbal abuse, financial abuse, and various forms of neglect all pose potential threats to residents. In addition to the policies maintained by the department, each center develops and maintains policies for identifying and preventing abuse and neglect. These policies, which the centers typically update on an annual basis, are intended to communicate to staff a consistent approach to protecting residents.

The IPP prepared for each developmental center resident also offers a form of protection. In addition to outlining residents' developmental goals and treatment plans, IPPs help protect residents by informing the staff about each resident's current needs and challenges. They also indicate how much staff supervision each resident requires. If residents do not receive adequate supervision, they risk harming themselves or others. In addition, if staff are not adequately trained, supervised, and informed of residents' needs, they risk inadvertently harming residents.

As shown in Figure 2, developmental center residents receive protection and support from department employees and other entities at varying levels and frequencies. On a day-to-day basis, residents interact most often with health care staff, such as nurses and psychiatric technicians, who provide routine supervision and medical services to residents. These employees are in a position to provide the most immediate protection to residents. Various levels of developmental center management provide oversight of health care staff and are also accountable for the centers' daily operations. These managers supervise health care staff, develop policies for staff members to follow, and review incidents in which residents suffered harm or alleged abuse to ensure that each resident's immediate safety needs are met. In addition, residents sometimes have occasion to interact with employees of the department's law enforcement division, the Office of Protective Services (OPS). OPS officers are on-site at each center and, in addition to performing general patrol and traffic enforcement duties, respond to alleged abuse of residents. Each center's OPS unit is led by a commander, who reports to the OPS director in the Developmental Centers Division at department headquarters in Sacramento.

Figure 2
Individuals and Entities Responsible for Resident Safety at Developmental Centers



Sources: California State Auditor's analysis of various individuals' and entities' relationships with and responsibilities to developmental center residents.

* Outside oversight agencies include the California Department of Public Health, which performs routine licensing and certification reviews of the developmental centers and advocates for the developmentally disabled, such as Disability Rights California, which interact with staff at the department's headquarters and developmental centers to obtain information used for monitoring safety.

The department's leadership in Sacramento also plays a significant role in ensuring residents' safety. Its Developmental Centers Division creates safety policies for all developmental centers to follow and monitors the operation of the centers. The department also reports information about the developmental centers to outside monitoring agencies, including Public Health. Public Health is required to perform regular on-site inspections, called surveys, of the health care facilities at developmental centers. These surveys are necessary for the facilities to establish and maintain their state licensure and federal certification. The federal certification is required by Centers for Medicare & Medicaid Services (CMS) as a condition of receiving federal funding for these facilities. Public Health conducts site visits to perform its surveys and to investigate complaints at each center and reports the results of these visits both to CMS and to the department. If centers have unresolved findings, including abuse allegations that have been poorly handled, it could place their ongoing ability to receive federal reimbursements in jeopardy.

Other monitoring agencies also operate as independent reviewers of safety at the developmental centers. For example, Disability Rights California (Disability Rights) has a legal right under certain circumstances defined in law to review investigative records that include residents' medical information, which is otherwise confidential under state law. Disability Rights also has federal authority and funding

to review incidents at the centers, which it has done in the past. For instance, in March 2012, Disability Rights conducted a preliminary review of the department's investigations of deaths, sexual assault allegations, and serious injuries at developmental centers. Although this review found that almost all of the cases were not suggestive of abuse or neglect, Disability Rights still raised some concerns about the department's investigations and made some recommendations to the department. For example, Disability Rights recommended that the department ensure that its medical staff maintain competencies in detecting signs of possible abuse and that the department augment its incident data reporting system to detect patterns of abuse and neglect. In response to these recommendations, in 2012, the department had a forensic nurse specialist provide OPS and other developmental center staff sexual assault forensic examination training and also launched a new department-wide incident tracking system—the Incident Reporting Information System—which is discussed in Chapter 2. In addition to reviews, Disability Rights can also bring class action lawsuits on behalf of the developmentally disabled community. For example, in 2009, Disability Rights settled litigation *(Capitol People First v. Department of Developmental Services)* requiring the State to seek funding for enhanced case management at centers and provide staff with information and training related to community living options.

To meet certain federal requirements, the State Council on Developmental Disabilities (State Council) was established by state law as an independent council for the purpose of providing planning and coordination of services for individuals with developmental disabilities. The State Council has an agreement with the department to deliver client rights and volunteer advocacy services for developmental center residents. This agreement allows it to have two staff members based at each center to ensure that residents' rights are protected and to ensure that residents get the services they need. In addition, the State Council produces a state plan in which it identifies ways to improve and increase services for disabled individuals. In its 2012–2016 State Plan, the State Council set a goal to be more involved in the planning and closure process of developmental centers and to work with state and federal entities to protect the rights of residents in those centers.

Reviews and investigations by OPS, department headquarters, Public Health, and other agencies provide feedback to developmental center staff and management on how to better support and protect residents. Information provided by these entities is sometimes accompanied by recommendations directed to the department to reform particular processes or address poor decisions by facility staff and residents. However, while various organizations exercise different kinds of oversight over the developmental centers, information often comes to light because it is reported by a resident or staff member within a center.

Reporting Abuse at a Developmental Center

State law requires developmental center staff to report abuse when they are aware of it and generally specifies that all center employees, including non-health care staff, are *mandated reporters.* This means that any employee who becomes aware of a situation that he or she reasonably believes could be abuse is obligated to report the situation to local law enforcement or to OPS. Failure to make this report is a misdemeanor punishable by a fine and jail time, as well as potential employee discipline. Developmental centers have policies for disciplining employees who fail to report abuse. State law requires developmental centers to report certain types of incidents to local law enforcement authorities, regardless of whether the incident was otherwise reported to OPS. The list of incidents requiring such reporting expanded in September 2012 to include the types of incidents listed in the text box.

Recent Changes to the California Department of Developmental Services' Requirements for Reporting Incidents to Local Law Enforcement

As of September 2012 developmental centers must report the following types of incidents involving their residents to local law enforcement, regardless of whether the Office of Protective Services investigated the incident:

- A death
- A sexual assault
- An assault with a deadly weapon by a nonresident of the developmental center
- An assault with force likely to produce great bodily injury
- An injury to the genitals when the cause of the injury is undetermined
- A broken bone when the cause of the break is undetermined

Source: Chapter 666, Statutes 2012, which amended Welfare and Institutions Code, Section 4427.5.

Reporting hotlines are available to any person, including employees. However, anonymous reporting does not relieve staff of the obligation to personally report incidents they are aware of. To provide the protection from retribution necessary to encourage employees to report incidents personally, developmental centers have policies that forbid retaliation against individuals making reports, and state law provides similar protections for developmental center employees.

Reports of abuse do not come only from developmental center employees and are not reported only to the department or OPS. Public Health's Web site has a phone number and a form for anyone to submit reports of abuse or neglect. In addition, Disability Rights, the resident rights advocacy group, has a phone number and a guide with instructions for reporting abuse.

Concerns About Resident Safety

Various external entities have expressed concern about safety conditions in the developmental centers in the past decade, and previous investigations have found problems related to resident safety. In 2002 the Office of the Attorney General (attorney general) published the results of a review of the organization and operations of the developmental centers and the predecessor to OPS, which at that time was called the Law Enforcement Division.

The attorney general's report made 28 recommendations to the department, among them observing that the law enforcement division did not provide competitive salary and benefits, was not properly equipped to fight crime, and was improperly organized to effectively serve its mission. As described in the previous section, in 2012 the Legislature addressed concerns about investigative practices at the developmental centers by passing legislation to expand the requirement that the centers report certain incidents to local law enforcement. Furthermore, media reports in 2012 about developmental center staff members abusing residents focused increased attention on issues of resident safety at the centers.

Public Health has also recently expressed concern about resident safety at the Sonoma Developmental Center (Sonoma). In its July 2012 recertification survey of Sonoma, Public Health noted dozens of safety deficiencies, including four issues that it believed put resident health and safety in immediate jeopardy. In December 2012, having found still more deficiencies at Sonoma, Public Health informed the department of its intention to terminate Sonoma's Medicaid provider agreement. In January 2013 the department withdrew certification for four of the 10 residential units at Sonoma licensed as intermediate care facilities for the developmentally disabled, and the department agreed not to request any federal reimbursement for the operation of these units until they can be recertified by Public Health. The department indicated that it would enter into a performance improvement plan for the remaining six units. The department's January 2013 decision allows Sonoma to continue to receive federal reimbursement for a portion of the operating costs associated with the remaining six units. In March 2013 the department entered into an agreement with Public Health to apply the performance improvement plan to the four decertified units, and Public Health in turn agreed to postpone action to discontinue those units' licenses to operate. As of June 2013 the department is continuing to work with Public Health to address concerns regarding Sonoma's residential units.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor to perform an audit of the policies and practices used by the department and other entities to protect developmentally disabled individuals living in the State's developmental centers. Table 1 outlines the audit committee's objectives and our methodology for addressing each one.

Table 1
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	We reviewed relevant laws, rules, regulations, judicial decisions, and other background materials.
2	Review and evaluate the California Department of Developmental Services' (department) rules, regulations, policies, and procedures established to address the special conditions of the population served with regard to protecting developmental center residents (residents) and preventing abuse in state-operated developmental centers to determine whether they comply with relevant laws. Further, determine the extent to which the department monitors and reviews these rules, regulations, policies, and procedures regularly to ensure that they are appropriate, effective, and routinely followed.	• To identify the actions the department required its employees to take to comply with laws and regulations, we obtained policies and procedures from the Developmental Centers Division and from the Fairview, Porterville, and Sonoma developmental centers. • To determine whether these policies and procedures comply with the law, we identified requirements in laws and regulations that apply to the developmental centers, and we determined whether the department's policies and procedures address those requirements. • To determine whether the department routinely reviewed its policies to ensure that they are appropriate and effective, we obtained relevant policies and information on when department staff had most recently updated them. • To determine whether developmental center employees routinely followed the requirements listed above, we performed the steps under audit objective 9. Also, we obtained a sample of 20 residents' individual program plans (IPP) from the Fairview, Porterville, and Sonoma developmental centers that had been updated in 2012. We determined whether the department recorded these residents' needs and planned activities in their IPPs in the detail required under laws, regulations, and department policies.
3	Examine the policies and procedures of the department's Office of Protective Services (OPS) with regard to protecting residents and preventing abuse in state-operated developmental centers to determine whether they comply with relevant laws and are designed to meet the department's responsibilities to protect its residents.	• To determine whether OPS policies and procedures comply with relevant laws, we compared its current policies to these laws and regulations. • To determine whether OPS policies and procedures were designed to meet the department's responsibilities to protect residents, we assessed the policies and procedures and considered the department's perspective on our conclusions.
4	Identify the actions OPS has taken to fulfill its responsibilities to protect residents in developmental centers and determine whether those actions are effective in protecting residents and preventing resident abuse.	• To identify actions OPS had taken to protect residents, we reviewed the OPS policy manual, interviewed department and OPS personnel, and reviewed records of activities undertaken by OPS personnel. • To determine whether OPS's actions have been effective, we considered our conclusions from other objectives of this audit.
5	Identify any performance standards OPS has developed regarding the protection of residents and the prevention of abuse. Determine whether the department regularly assesses the reasonableness of these standards and ensures that they are being met.	• We obtained policies and procedures from the department and OPS. • To determine whether OPS has performance standards for resident protection, we interviewed department and OPS personnel. • To determine whether OPS ensures that its performance standards are being met, we obtained documentation of records reflecting how the department and OPS track activity related to these standards.
6	Review and evaluate the training requirements and qualifications for peace officers and management staff in OPS to determine:	To identify the minimum qualifications for peace officers and management staff, we interviewed department staff and reviewed available documentation.
	a. Whether they comply with applicable laws, rules, and regulations.	We interviewed the OPS training officer and evaluated available documentation to determine whether OPS peace officers and management staff were in compliance with the Commission on Peace Officer Standards and Training (commission) state regulations.

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	AUDIT OBJECTIVE	METHOD
	b. Whether additional training is provided for peace officers handling cases involving dependent minors and adults.	To identify any additional training involving interactions with dependent minors and adults, we interviewed relevant staff and reviewed available documentation.
	c. Whether hiring and recruitment practices for peace officers are sufficient to attract highly qualified candidates.	• We reviewed the *State Personnel Board Merit Selection Manual* to identify hiring and recruitment best practices for civil service employees. Also, we identified and reviewed commission regulations for hiring peace officers. • We interviewed relevant staff to identify the recruitment and hiring practices of OPS.
	d. How they compare to law enforcement agencies.	• We identified that the California Department of Corrections and Rehabilitation (Corrections), California Department of State Hospitals (State Hospitals), and California Department of Social Services (Social Services) have law enforcement agencies that are comparable to OPS. • We interviewed relevant staff from Corrections, State Hospitals, and Social Services and reviewed available documentation on hiring and recruitment practices, additional training provided on interacting with select populations, and minimum training requirements and qualifications. • Based on our review of the information and the comparison with OPS, we determined that OPS's hiring and recruitment practices and minimum training requirements are similar to those of Corrections, State Hospitals, and Social Services. Also, we found that OPS's minimum qualification requirements are similar to those of Social Services and State Hospitals. However, we concluded that the minimum qualifications are not comparable to those of Corrections, since Corrections' Special Agent classification, used for the purpose of our analysis because of the investigative duties related to the classification, requires a minimum of five years' investigative experience for the entry-level position, whereas OPS does not require any experience for its entry-level class titles of Peace Officer I and Investigator if certain other requirements are met.
7	Review and evaluate the department's and OPS's overtime policies to determine:	With the assistance of legal counsel, we reviewed relevant laws, regulations, and other background materials applicable to the department and OPS.
	a. Whether they comply with applicable laws, rules, regulations, and state guidelines.	We compared the department's and OPS's policies and procedures related to overtime with the applicable laws, rules, regulations, and bargaining unit agreements.
	b. Whether the department and OPS have policies and procedures to provide monitoring and oversight of overtime usage, including determining staffing needs, approving overtime requests, and ensuring the most cost-effective use of human resources.	• We interviewed key staff at the Fairview, Porterville, and Sonoma developmental centers to assess their roles and responsibilities with regard to overtime at the facilities and to identify what pertinent policies, procedures, and internal controls are in place to ensure that overtime is appropriate and authorized. • We reviewed 10 instances of overtime at the Fairview, Porterville, and Sonoma developmental centers between 2008 and 2012 to determine whether the overtime was justified, properly authorized, and correctly paid in accordance with the bargaining unit agreements. • We reviewed eight health care and OPS employees and eight additional OPS employees with the highest numbers of average overtime hours paid from January 2008 through December 2012, and investigated the reasons why these employees worked so much overtime.
	c. Whether staffing conditions justify the need for overtime and the amount of overtime used.	We reviewed industry standards applicable to staffing for health care facilities, reviewed studies on the impact of overtime on the health and safety of patients and residents, and interviewed management at the Fairview, Porterville, and Sonoma developmental centers. In addition, we compared these studies with our analysis of the department's payroll records.
	d. How the overtime policies and pay compare to those for other comparable state agencies.	• We reviewed job classifications and responsibilities with the greatest responsibility for protecting residents from abuse and found three other agencies with similar job classifications. We identified Corrections, State Hospitals, and Social Services as agencies with duties and job classifications comparable to those of the health care and OPS staff within the department. • We reviewed payroll data from the California State Controller's Office for the department's health care and OPS staff and compared this data to other state agencies with similar job classifications.

	AUDIT OBJECTIVE	METHOD
8	Review and evaluate the process by which employees, residents, and others can report allegations of resident abuse in state-operated developmental centers and determine, among other things, whether the process includes any whistleblower protections.	We reviewed incident-reporting policies and procedures from the department, including policies and procedures describing how clients, developmental center employees, and others can report abuse. During this review, we determined whether these policies and procedures included descriptions of whistleblower protections.
9	Review and evaluate the department's and OPS's rules, regulations, policies, and procedures for investigating allegations of resident abuse in state-operated developmental centers to determine whether they comply with relevant laws, rules, and regulations; are effective; and are routinely followed.	• We identified the processes health care staff and OPS use to review and investigate incidents involving residents. • To determine whether the policies and procedures for investigating allegations of resident abuse comply with laws and regulations, we did the following: - Reviewed abuse prevention and investigation policies and procedures from the department and OPS. - Identified laws and regulations relating to investigating allegations of resident abuse at developmental centers. - Compared the policies and procedures we reviewed with the laws and regulations we identified to determine whether any of the policies and procedures conflicted with or did not comply with applicable laws and regulations. • To determine whether the department's procedures for investigating alleged abuse are effective, we compared its procedures to guidance that the Centers for Medicaid & Medicare Services gave to health care facilities on this subject. • To determine whether OPS's procedures for investigating alleged abuse are effective, we compared their procedures to written guidance used internally by the California Highway Patrol (CHP). • To determine whether the department's and OPS's procedures for investigating alleged abuse were routinely followed, we selected 60 incidents of resident abuse that the department's health care staff reviewed, 48 of which OPS also investigated, and determined whether the department and OPS followed their procedures for reviewing and investigating the incidents.
10	Determine how the department and OPS document and track cases of resident abuse in state-operated developmental centers. Using that information, determine the following:	We interviewed relevant staff from the department and the developmental centers that we visited to determine their process for documenting and tracking cases of resident abuse.
	a. The number of cases of resident abuse that have been documented within the past five years.	We examined the incident data for each developmental center.
	b. The disposition of those cases, such as the number investigated and the number that resulted in criminal prosecution.	We examined the incident data from the developmental centers that we visited and gathered data on the other facilities and certain dispositions for all facilities from the department's Developmental Centers Division.
11	Determine the role of the California Department of Public Health (Public Health) with regard to protecting residents and preventing abuse in the developmental centers, and whether Public Health is meeting its obligations regarding resident safety.	• We examined Public Health's records of survey visits, citation penalties, deficiencies cited, and complaint or incident investigations to determine whether Public Health is in compliance with the laws and regulations related to protecting residents of the developmental centers. We also used these records to assess the quality of Public Health's oversight activities over the developmental centers. • We interviewed management at Public Health to determine its role in monitoring conditions, investigating allegations of abuse, and enforcing violations in the developmental centers.
12	Identify any other agencies and their respective roles in monitoring, investigating, and/or reporting allegations of abuse in the developmental centers.	To identify and gain an understanding of other agencies and their roles in the developmental centers, we conducted research on the relationships between the developmental centers and outside entities and we reviewed an October 2012 Legislative Analyst's Office report on the developmental centers.

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	AUDIT OBJECTIVE	METHOD
13	Identify any studies conducted in the area of resident abuse in the developmental centers located in California within the last five years. Determine whether any recommendations were made and the extent to which those recommendations were implemented. In addition, determine the extent to which the recommendations in the 2002 report from the Office of the Attorney General (attorney general) were implemented.	• We reviewed the attorney general's 2002 report and reviewed other available documentation to identify and evaluate the recommendations and the status of their implementation. • We performed research and contacted the other agencies identified in objective 12 to see whether they had conducted any studies in the past five years and, if so, obtain those studies or reports, and we evaluated the implementation of the recommendations relating to the area of resident abuse in the developmental centers. Our research found a preliminary report by Disability Rights California with applicable recommendations and several annual reports prepared by the State Council on Developmental Disabilities. Only the most recent annual report (fiscal year 2011–12) had recommendations that addressed the area of resident abuse. Based on our analysis, we determined that the department and OPS have addressed most of the recommendations contained in these reports or are currently working to implement them.
14	Determine whether the policies, procedures, and practices of OPS are consistent with best practices used by a selection of comparable agencies in the following areas:	To determine whether OPS's policies, procedures, and practices are consistent with those used by Corrections, State Hospitals, and Social Services, we interviewed relevant staff from these three departments and reviewed available documentation to identify their practices and compare them with those of OPS.
	a. Disciplinary process for employees and peace officers as it relates to violations involving resident safety.	Using information we obtained from the department's legal counsel and policies on the disciplinary process, we compared OPS's practices to those of Corrections, State Hospitals, and Social Services. Our review found that OPS's disciplinary process is identical to that of Corrections, State Hospitals, and Social Services, and that it has an additional policy that addresses disciplinary actions when resident abuse is substantiated.
	b. Process for investigating allegations of resident abuse, including case closure rates and any other outcomes tracked.	As stated under objective 9, we compared OPS's procedures for investigating abuse allegations with the CHP's procedures and other best practices. Additionally, we evaluated OPS's performance measures and sought these measures, such as case closure rates, from Corrections, State Hospitals, and Social Services.
	c. Compensation policy for peace officers.	• Using the information on compensation gathered in interviews with relevant staff and available documentation obtained from Corrections, State Hospitals, Social Services, and OPS, we compared salaries and benefits. • To compare OPS's compensation to that of other local law enforcement entities, we selected entities within close proximity of each developmental center. We interviewed the selected local entities and reviewed documentation to develop an understanding of their compensation practices.
15	Review and assess any other issues that are significant to the protection of residents in the developmental centers.	We identified several contracts that the department had entered into that were relevant to our audit. These contracts included agreements for consulting services related to OPS law enforcement practices and developmental center resident advocacy, and for having a CHP employee function as the Sonoma Developmental Center's OPS commander. We evaluated these contracts to determine their impact on OPS's current operations and future policies and procedures as well as resident safety.

Sources: California State Auditor's analysis of Joint Legislative Audit Committee audit request number 2012-107, planning documents, and analysis of information and documentation identified in the column titled *Method*.

Assessment of Data Reliability

In performing this audit, we obtained electronic data files extracted from the information systems listed in Table 2. The U.S. Government Accountability Office, whose standards we follow, requires us to assess the sufficiency and appropriateness of computer-processed information that is used to support findings, conclusions, or recommendations. Table 2 shows the results of our assessment.

Table 2

Methods of Assessing Data Reliability

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
California Department of Developmental Services (department) California Department of Corrections and Rehabilitation California Department of State Hospitals California Department of Social Services Payroll data as maintained by the California State Controller's Office (state controller) Uniform State Payroll System for 2008 through 2012	To calculate the total amount of regular and overtime pay, the average number of employees by pay type for each of the departments listed, and overtime pay as a percent of total earnings—the sum of regular and overtime pay— for 2012. To calculate the total amount of regular and overtime pay, and overtime pay as a percent of total earnings, by employee class title for each of the departments listed for 2012. To calculate overtime paid as a percent of total earnings for the department's Office of Protective Services' (OPS) employees as compared to all other department employees by location and departmentwide for each year between 2008 and 2012. For a selection of 62 department employees who were paid at least the same amount in overtime pay as regular pay for the period of 2008 through 2012, calculate the total amount of regular pay and overtime pay, and the number of employees by class title. For a selection of eight department employees who were paid at least 150 percent of their regular pay in overtime for the period of 2008 through 2012, identify the employee's class title and work location, calculate the average weekly hours worked by calendar year, and total the employee's regular pay and overtime pay.	• We performed data-set verification procedures and electronic testing of key data elements and found no issues. • We relied on the completeness testing performed as part of the State's annual financial audit for payroll transactions between January 2008 and June 2012. Since the State's financial audit for fiscal year 2012–13 is still in progress, we cannot rely on this report to verify completeness between July 2012 and December 2012. However, because we found the payroll data to be complete between January 2008 and June 2012, we have reasonable assurance that the payroll data for the period of July 2012 through December 2012 are also complete. Consequently, we found the data to be complete. • We relied on the accuracy testing performed as part of the State's annual financial audit for payroll transactions between January 2008 and June 2011. For the period July 2011 through December 2012, we performed accuracy testing on a selection of 10 regular or overtime payroll transactions by tracing key data elements to supporting documentation and found no errors. • We performed additional accuracy testing on two key data elements—overtime hours paid and work location—for the selection of 62 department employees by tracing key data elements to supporting documentation and found no errors.	Sufficiently reliable for the purposes of this audit.

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INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
Department Leave accounting data maintained by the state controller's California Leave Accounting System for 2008 through 2012	To calculate the total accrued compensating time off leave hours for a selection of eight department employees who were paid at least 150 percent of their regular pay in overtime for the period of 2008 through 2012.	• We performed data-set verification procedures and electronic testing of key data elements and found no issues. • We performed accuracy testing on a random sample of 31 total unique payroll transactions—selected from 62 department employees who were paid at least the same amount in overtime as regular pay for the period of 2008 through 2012. Since our initial random sample of 29 only contained three transactions where the employee accrued compensating time off, we augmented our testing by selecting the next two transactions in our sample where the employee accrued compensating time off hours to gain additional assurance of the accuracy of these hours. We found no errors. • To verify completeness, we used the initial random sample selected for accuracy testing—described in detail above—in which we selected 29 unique payroll transactions. We traced payroll timekeeping documents to the leave accounting data to determine if accrued compensating time off was properly recorded in the leave accounting data. We found no errors.	Sufficiently reliable for the purposes of this audit.
Fairview Developmental Center Incident Reporting Management Application (IRMA) Data for 2008 through August 2012	Determine the number of documented alleged resident abuse cases. Determine the disposition of those cases, such as the number investigated and the number substantiated.	• We performed data-set verification procedures and electronic testing of key data elements and found no significant issues. • To test the accuracy of the developmental center's data, we randomly selected a sample of 29 incidents and verified that key data elements matched source documentation. We found one error within the special investigation number data field. Therefore, we randomly selected another 17 incidents to verify the special investigation number data field matched source documentation. We found no additional errors. • To test the completeness of the developmental center's data, we haphazardly selected 29 incidents and traced them from hardcopy files back to the electronic database. We found the data to be complete.	Sufficiently reliable for the purposes of this audit.
Fairview Developmental Center Incident Reporting Information System Data for August 2012 through December 2012	Determine the number of documented alleged resident abuse cases. Determine the disposition of those cases, such as the number investigated and the number substantiated.	• We performed data-set verification procedures and electronic testing of key data elements and found no issues. • To test the accuracy of the developmental center's data, we randomly selected a sample of 29 incidents and verified that key data elements matched source documentation. We found no errors. • To test the completeness of the developmental center's data, we haphazardly selected 29 incidents and traced them from hardcopy files back to the electronic database. We found the data to be complete.	Sufficiently reliable for the purposes of this audit.
Porterville Developmental Center Risk Management Database (RMD) Data for 2008 through 2012	Determine the number of documented alleged resident abuse cases. Determine the disposition of those cases, such as the number investigated and the number substantiated.	• We performed data-set verification procedures and electronic testing of key data elements and found no significant issues. • Although accuracy testing is not required because we found the data to be incomplete, we decided the results of the testing would be important and informative. To test the accuracy of the developmental center's data, we randomly selected a sample of 29 incidents and verified that key data elements matched source documentation. We found no errors. • To test the completeness of the developmental center's data, we haphazardly selected 29 incidents and traced them from hardcopy files back to the electronic database. We found one incident report that was not documented in the RMD. As a result, the data is incomplete.	Not sufficiently reliable for the purposes of this audit. Nevertheless, we present these data because they represent the best available data source of this information.

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
Sonoma Developmental Center New Incident Reporting Management Application Data for 2008 through October 2012	Determine the number of documented alleged resident abuse cases.	• We performed data-set verification procedures and electronic testing of key data elements and found no significant issues. • To test the accuracy of the developmental center's data, we randomly selected a sample of 29 incidents and verified that key data elements matched source documentation. We found no errors. • To test the completeness of the developmental center's data, we haphazardly selected 29 incidents and traced them from hardcopy files back to the electronic database. We found the data to be complete.	Sufficiently reliable for the purposes of this audit.
Sonoma Developmental Center New Incident Reporting Management Application (NIRMA) Data for 2008 through October 2012	Determine the number of documented alleged resident abuse cases that were investigated.	• We performed data-set verification procedures and electronic testing of this key data element and found no significant issues. • We did not test the accuracy of the number of resident abuse cases investigated because developmental center staff informed us that its employees do not consistently use the special investigation number—the data field that indicates whether a case was investigated—in NIRMA. • To test the completeness of the developmental center's data, we haphazardly selected 29 incidents and traced them from hardcopy files back to the electronic database. We found the data to be complete.	Not sufficiently reliable for the purposes of this audit. Nevertheless, we present these data because they represent the best available data source of this information.
Sonoma Developmental Center Incident Reporting Information System (IRIS) Data for November 2012 through December 2012	Determine the number of documented alleged resident abuse cases. Determine the disposition of those cases, such as the number investigated.	• We performed data-set verification procedures and electronic testing of key data elements and found no issues. • We did not perform accuracy or completeness testing because hard-copy source documentation was not available for this review. Alternatively, following the U.S. Government Accountability Office's guidelines, we could have reviewed the adequacy of selected system controls that include general and application controls. However, we did not conduct these reviews because the data we are analyzing was for one location for a two month period. We determined that the level of effort required to perform these reviews was not cost effective.	Undetermined reliability for the purposes of this audit. Nevertheless, we present these data because they represent the best available data source of this information.
Sonoma Developmental Center's OPS Microsoft Excel files Data for 2008 through 2012	Determine the disposition of alleged resident abuse cases, such as the number substantiated.	• We performed data-set verification procedures and electronic testing of key data elements and found no significant issues. • To test the accuracy of the developmental center's data, we randomly selected a sample of 29 incidents and verified whether the key data elements matched source documentation. We found two errors in the OPS case number data field, seven errors in the case type data field, and six errors in the disposition data field. • To test the completeness of the developmental center's data, we haphazardly selected 29 incidents and traced them from hardcopy files back to the electronic database. We found the data to be complete.	Not sufficiently reliable for the purposes of this audit. Nevertheless, we present these data because they represent the best available data source of this information.

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INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
California Department of Developmental Services' Developmental Centers Division Microsoft Excel files Data for 2008 through 2012	For Canyon Springs and Lanterman determine the number of documented alleged resident abuse cases and of those cases the number investigated and substantiated. For all five developmental centers, determine the disposition of alleged resident abuse cases, such as the number sent to the district attorney and the number that resulted in criminal complaints filed by the district attorney within the past five years.	We did not test the reliability of these data because it would not be cost-effective to trace this summary-level data back to the individual transactions that support the totals.	Undetermined reliability for the purposes of this audit. Nevertheless, we present these data because they represent the best available data source of this information.
California Department of Public Health (Public Health) Automated Survey Processing Environment (ASPEN) Complaint and entity-reported incident (incident) data for fiscal years 2008–09 through 2011–12.	To determine the classification and the amount of time it took Public Health to initiate investigations into complaints and incidents.	• As we reported in a previous audit report, *Department of Health Services: Its Licensing and Certification Division Is Struggling to Meet State and Federal Oversight Requirements of Skilled Nursing Facilities* (2006-106, April 2007), the federal database Public Health uses to track its investigations, ASPEN, has weak controls that preclude Public Health (previously part of the Department of Health Services) from preventing erroneous data entry or detecting data errors for key data fields such as dates when complaints are received and investigated. • There were 10,746 complaints and incidents in our audit period and nine of them were assigned to more than one priority level. We did not include these nine in our testing. However, through our testing we discovered data limitations. Specifically, we found 863 of the 10,737 complaints and incidents we tested either missing a date or with an investigation initiation date before the intake date. Although Public Health provided documents indicating that its investigation was initiated after the complaint or incident was received for four of these occurrences, we could not easily gather the documents needed to find the missing dates, evaluate illogical data, or rule out data entry errors for the remaining 859 records. • Public Health indicated that it has requested the federal government to make improvements to ASPEN.	Not sufficiently reliable for the purposes of this audit. Nevertheless, we present these data because they represent the best available data of this information.
California Department of Public Health (Public Health) Automated Survey Processing Environment (ASPEN) Survey data for fiscal years 2005–06 through 2011–12.	To determine whether state licensing and federal certification surveys and certification revisits occurred when required.	Because Public Health indicated that it has requested the federal government to make improvements to ASPEN, we did not perform any further testing of the data we obtained from the federal database.	Undetermined reliability for the purposes of this audit. Nevertheless, we present these data because they represent the best available data of this information.

Sources: California State Auditor's analysis of various documents, interviews, and data obtained from the entities listed above.

Chapter 1

THE CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES' PROCEDURES FOR INVESTIGATING ALLEGATIONS OF ABUSE ARE NOT ALWAYS FOLLOWED OR ALIGNED WITH BEST PRACTICES

Chapter Summary

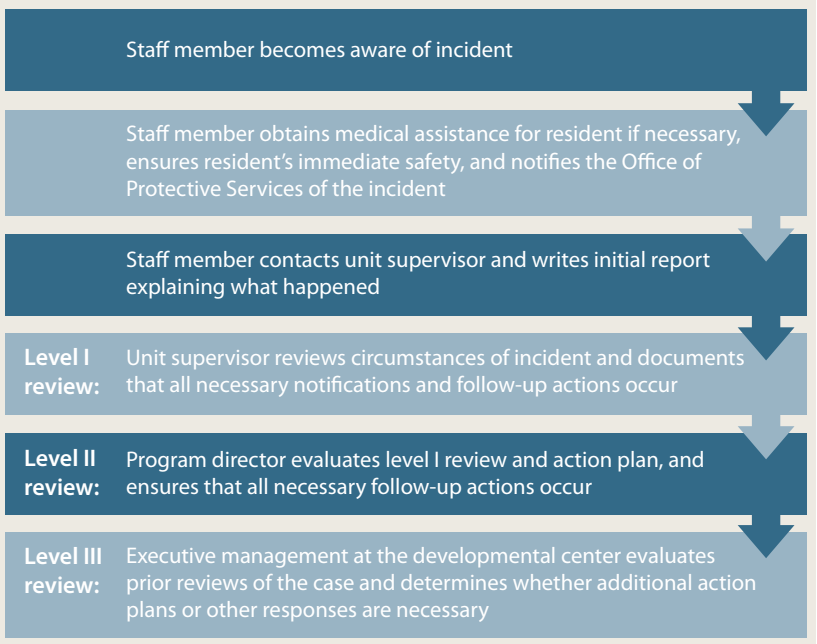
Health care staff with the most direct interaction with developmental center residents (residents) generally conduct incident reviews according to procedures but sometimes do not provide timely incident notifications to the California Department of Developmental Services' (department) Office of Protective Services (OPS). Despite its important role in protecting residents, OPS does not appear to routinely follow its established procedures for collecting evidence and other information pertinent to its investigations. In addition, OPS policies do not require certain actions that are essential to effective investigations.

Health Care Staff Generally Follow Appropriate Procedures in Their Reviews of Incidents

When developmental center staff become aware that a resident has experienced an incident involving injury or inappropriate risk of harm (incident), they review the circumstances. We examined a selection of reviews that health care staff conducted for incidents involving residents of developmental centers, and found that health care staff usually followed established procedures and that the procedures were appropriate and in compliance with federal and state guidance. The main purposes of the reviews conducted by health care staff are to document the circumstances of the incident and to ensure that all necessary steps are promptly taken for the immediate and ongoing safety of the developmental center resident affected by the incident. The key area of noncompliance by health care staff we found was that they did not always promptly notify OPS of incidents.

While federal laws do not mandate a specific process for these reviews, the Centers for Medicare & Medicaid Services expects facilities' processes for reviewing such incidents to be replicable and reliable. The department's Developmental Centers Division requires each developmental center to have a review process for health care staff to follow, but it does not prescribe the specifics of these processes. Each center we visited has developed a detailed process for health care reviews that holds specified staff accountable for ensuring that particular steps are taken in the course of each review. Figure 3 illustrates the common characteristics of these reviews.

Figure 3
Process for Incident Reviews by Health Care Staff at Developmental Centers



Sources: California State Auditor's summary of policies and procedures at Fairview, Porterville, and Sonoma developmental centers.

Our examination of health care reviews indicated that health care staff usually followed the developmental centers' procedures. We examined 20 health care reviews at each of the three developmental centers we visited—Fairview Developmental Center (Fairview), Porterville Developmental Center (Porterville), and Sonoma Developmental Center—including 16 incidents of possible abuse that resulted in OPS investigations and four injury incidents that OPS did not investigate.[4] For each health care review, we looked for evidence of eight actions that could have occurred, depending on the type of incident and according to developmental center policy, such as prompt notification of OPS by health care staff and supervisors' approval of the health care reviews. Of 396 applicable observations, we found nine deficiencies in the health care staff's reviews. As shown in Table 3, seven of these instances of noncompliance related to staff not providing prompt incident notifications to OPS. While health care staff's first priority after an incident involving a resident is to ensure that the resident's

[4] OPS policy requires OPS to investigate all allegations of abuse and certain severe or suspicious injuries. However, for non-severe and non-suspicious injuries of known origin, health care staff may notify OPS of the injury, but OPS policy does not require it to investigate the circumstances.

immediate needs are addressed, a notification to OPS must occur quickly if OPS is to have the best opportunity to collect evidence from an uncorrupted incident scene.

Table 3
Number of Instances in Which Health Care Incident Review Procedures Were Not Adequately Followed

OBSERVATION NUMBER	REVIEW PROCEDURE	INSTANCES IN WHICH PROCEDURES WERE NOT ADEQUATELY FOLLOWED				APPLICABLE NUMBER OF OBSERVATIONS*
		FAIRVIEW	PORTERVILLE	SONOMA	TOTAL	
1	Health care staff reported the incident to Office of Protective Services (OPS) within two hours.†	1	1	5	7	58
2	A physician or registered nurse documented a meaningful examination of the alleged victim.	0	0	0	0	55
3	The initial incident reporter documented a clear, detailed description of the incident on the required form.	2	0	0	2	60
4	If the accused was an employee or third party, the health care review record indicates that the accused was promptly removed from resident care.	0	0	0	0	24
5	If the accused was another resident, the health care review record indicates that staff immediately initiated a protection plan for all residents involved.	0	0	0	0	19
6	The level I review by the unit supervisor appears to be complete, with appropriate detail and plans of action.	0	0	0	0	60
7	The level II review by the program director appears to be complete, with appropriate plans to prevent recurrence.	0	0	0	0	60
8	The level III review by the executive director (or designee) appears to be complete, with appropriate determinations of whether further investigation is needed.	0	0	0	0	60
	Totals	**3**	**1**	**5**	**9**	**396**

Sources: California State Auditor's analysis of 60 health care review files related to incidents that occurred between January 1, 2010, and December 31, 2012. We examined 20 health care review files at Fairview Developmental Center, 20 at Porterville Developmental Center, and 20 at Sonoma Developmental Center.

* Some of the review procedures listed did not apply to all 60 incidents we reviewed. For example, if the accused was a resident, review procedure 4 did not apply.

† State law requires mandated reporters to report potential abuse immediately or as soon as practically possible, but does not define a time limit that reporters must meet to satisfy this requirement. We noted that Porterville's policy requires staff to notify OPS of reportable incidents no later than two hours following staff's discovery of the incident. We identified this as a best practice, and we used this standard in our testing of this requirement.

Specifically, as discussed in the Introduction, developmental center staff are mandated reporters, which means they must promptly report incidents of possible abuse to OPS or local law enforcement. However, in our testing, we found seven instances in which clinical staff did not notify OPS within two hours that an incident had occurred. These delays ranged from two and a half hours to nine days. The health care supervisors who reviewed the case in which reporting was delayed by nine days noted that all staff would receive a reminder of the importance of proper communication to all parties following an incident.

We asked the developmental centers why these delays occurred. Fairview explained that staff appear not to have known that a particular injury needed to be reported to OPS, and the subsequent supervisory review discovered and corrected this error. Sonoma agreed that notification to OPS should have occurred sooner but was able to demonstrate that for one incident the notification was late because, although initially the incident was judged not to require reporting, subsequently the program director's review elevated the incident's categorization to a report of neglect, a form of resident mistreatment that requires OPS notification.

OPS Did Not Routinely Follow Department Policies and Procedures When Conducting Incident Investigations

Although OPS is an important part of the department's system for protecting residents of the developmental centers, the quality of OPS's investigative work frequently fell short of the standards established in its policies. While health care reviews may indicate that staff failed to follow developmental centers' policies, their management generally looks to OPS to substantiate whether policy infractions have occurred. To fulfill this responsibility and to collect evidence for potential criminal prosecutions, OPS investigates every allegation of abuse at the centers. We reviewed 16 OPS investigations of alleged or potential abuse at each of the three developmental centers we visited (a total of 48 investigations). In this review, we found that OPS frequently did not follow its investigation procedures. For example, OPS did not routinely collect written declarations from staff during investigations and, in the case of Sonoma, did not always attempt to communicate with the alleged victims of harm.

In our review of 48 OPS investigations, OPS did not routinely collect written declarations from staff during investigations and, at one developmental center, did not always attempt to communicate with the alleged victims of harm.

OPS Conducts Investigations of Alleged Resident Abuse

As the primary law enforcement authority at the developmental centers, OPS conducts investigations that the centers use to ensure that employees who harm residents are held accountable, and that local district attorneys use to prosecute employees and residents who commit criminal acts at the centers. When a preliminary investigation by an OPS first responder (generally a peace officer) determines that more information is necessary to determine whether abuse occurred, OPS investigators will conduct an in-depth investigation. After OPS investigators, who generally have more training and experience than OPS peace officers, conduct these more thorough investigations, they submit a report of findings to their supervisor for review. After supervisory review, the OPS commander communicates the investigation results to the developmental center's executive management for review and

potential follow-up when violations of the center's policies have been substantiated. As shown in Table 4, the department has documented 4,345 allegations of abuse in the past five years. While OPS would perform at least some initial review on all these cases, 1,018 of them were investigated by an OPS special investigator, a process we further describe in this chapter. As indicated in Table 4, of the allegations of abuse 183 were substantiated and 82 were sent to district attorneys for criminal prosecution.

Table 4
Allegations of Resident Abuse in Developmental Centers
2008 Through 2012

DEVELOPMENTAL CENTER	ALLEGATIONS OF RESIDENT ABUSE	OFFICE OF PROTECTIVE SERVICES' (OPS) SPECIAL INVESTIGATIONS*	SUBSTANTIATED CASES OF ABUSE†	CASES OF ABUSE SENT TO DISTRICT ATTORNEY	CRIMINAL COMPLAINTS FILED BY DISTRICT ATTORNEY‡
Canyon Springs	845	76	9	4	0
Fairview	1,072	247	85	15	3
Lanterman	552	114	22	6	3
Porterville	929	168	23	53§	18
Sonoma	947	413	44	4	3
Totals	**4,345**	**1,018**	**183**	**82**	**27**

Sources: California State Auditor's (state auditor) analysis of data obtained from the California Department of Developmental Services (department) and from the incident tracking databases used by Fairview, Porterville, and Sonoma developmental centers.

Note: Refer to Table 2, beginning on page 17, for the discussion on the reliability of the data presented here.

* The department's policy states that an OPS officer will conduct a preliminary investigation for every allegation of abuse. OPS management will request a special investigation if additional information is required to determine the validity of the allegation.

† Not all substantiated cases of abuse are sent to the district attorney, because allegations of abuse may be substantiated under criminal or administrative criteria. Only criminal abuse cases are sent to the district attorney, while the department handles administrative cases of abuse internally. However, we could not determine the number of administrative abuse cases versus criminal because the developmental centers do not distinguish between criminal or administrative cases of abuse in their data. Additionally, the department stated that the count of substantiated cases of abuse does not include criminal abuse cases referred to outside law enforcement, such as the local police.

‡ The department could not provide the number of substantiated allegations of resident abuse that resulted in a guilty verdict. However, it could provide the number of substantiated allegations for which the district attorney filed a criminal complaint.

§ Porterville's incident data indicates that it sent 30 cases to the district attorney without substantiating the incident through a special investigation. The data show that most of these cases were resident-to-resident aggressive acts where the victim requested prosecution of the alleged abuser.

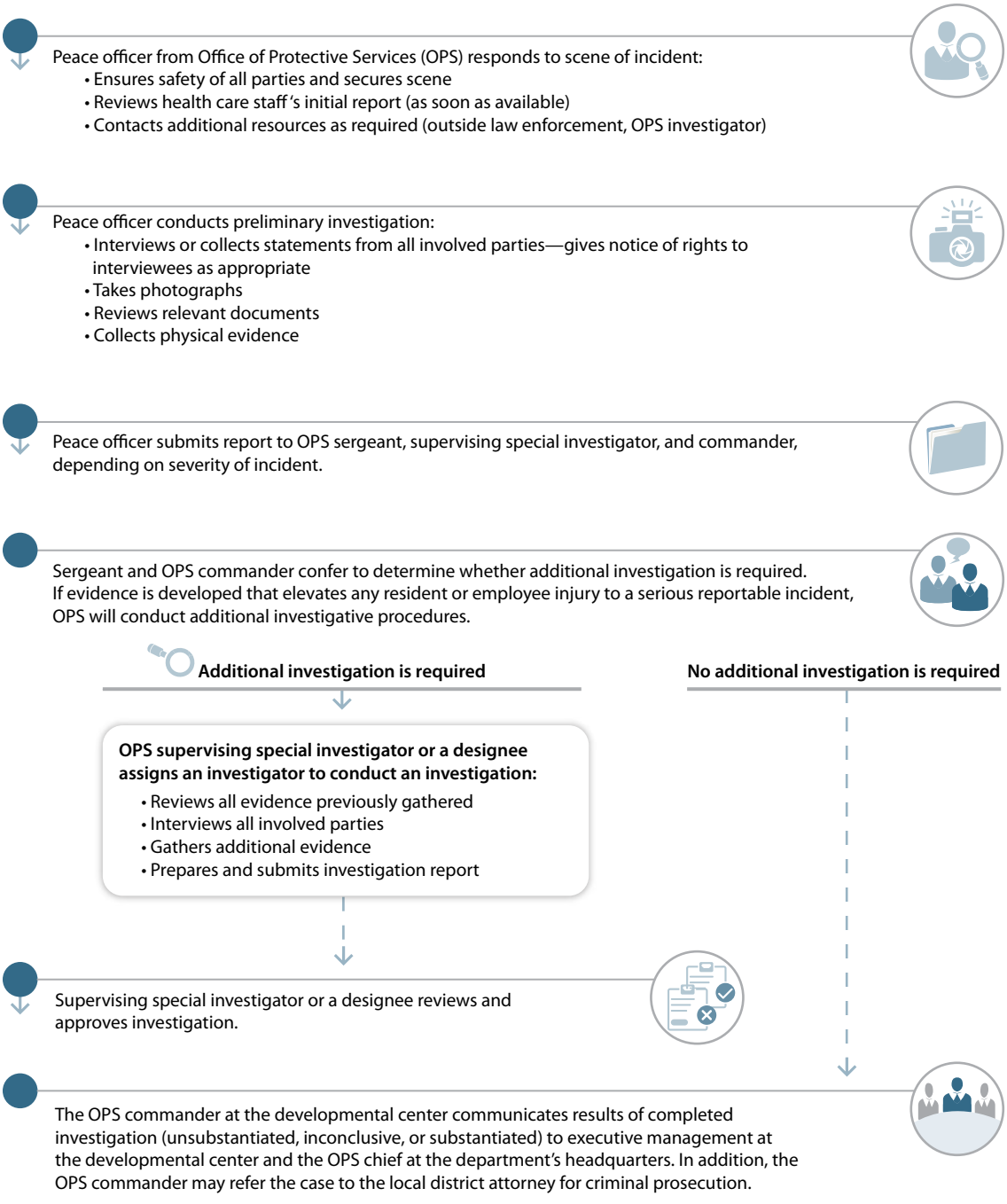
Before a criminal charge or administrative action can be brought against someone accused of abusing a resident, an investigator must gather sufficient evidence to demonstrate that the abuse indeed occurred. Because the standard of proof is higher in a criminal proceeding than it is in an administrative proceeding, district attorneys sometimes need different types and a higher quality of information before taking action against abusers. Sometimes, the same incident has the possibility of prompting both criminal charges and administrative actions, and the information gathered during an investigation can be used to support both types of reviews.

To collect the evidence needed to hold staff accountable for violations of law and policy, OPS conducts two types of investigations that require similar actions. One type of investigation focuses on violations of departmental or developmental center policies that may have occurred (administrative investigation). At the end of an administrative investigation, OPS will advise developmental center management of the investigation results, and management will determine whether adverse action will be taken against any employee. Administrative investigations are essential to determining staff members' compliance with the department's policy forbidding resident abuse. Under the department's "zero-tolerance" policy, staff members alleged to have abused residents are immediately removed from resident contact and, if the allegations are substantiated, are subject to adverse action, including potential termination. The other type of investigation focuses on whether a crime was committed (criminal investigation). At the end of a criminal investigation, if OPS substantiates that someone committed a crime, the case may be referred to the district attorney. As Figure 4 indicates, the steps for these two types of investigations are similar in many respects.

OPS's policy does not indicate who is responsible for deciding whether to refer a case to the district attorney when a resident or employee is accused of abuse and the investigation supports the allegation.

During our review of OPS policies, we noted that the responsibility for determining whether to refer a criminal investigation to the district attorney is not clearly defined in its policies. The policy states that when a resident is accused of abuse and the investigation supports the allegation, a conference will be held between OPS and department management to determine whether the case will be referred. This policy is silent on who is ultimately responsible for deciding to refer a case to the district attorney. Similarly, for situations in which an employee is accused of abuse and the investigation supports the allegation, the policy does not indicate who is responsible for deciding whether to refer the case to the district attorney. Although the department informed us that, when a staff member is the subject of the substantiated investigation, OPS always determines whether to refer a case to the district attorney, this decision-making responsibility is not clearly stated in OPS policy. If the department does not make clear who is responsible for these decisions, residents and other stakeholders affected by specific investigations do not know who is accountable for these key decisions about their cases.

Figure 4
Process for Incident Investigations by the Office of Protective Services at Developmental Centers



Source: California State Auditor's summary of policies and procedures in the OPS manual.

OPS Frequently Failed to Collect Required Evidence During Its Investigations

As discussed in the previous section, OPS investigations are invaluable in protecting residents from further abuse and neglect. Any shortcomings in these investigations can make it less likely that perpetrators will receive appropriate disciplinary action or face criminal charges. We reviewed the case files for 16 investigations of alleged abuse at each of three developmental centers (a total of 48 investigations). For each investigation, we looked for evidence of eight actions that could have occurred, depending on the type of incident and according to OPS policy, which resulted in 267 applicable observations. As indicated in Table 5, we found a total of 54 deficiencies in OPS's investigations, 34 of which occurred at Sonoma.

Table 5
Number of Instances in Which the Office of Protective Services' Investigative Procedures Were Not Adequately Followed

OBSERVATION NUMBER	INVESTIGATIVE PROCEDURE	INSTANCES IN WHICH PROCEDURES WERE NOT ADEQUATELY FOLLOWED				APPLICABLE NUMBER OF OBSERVATIONS*
		FAIRVIEW	PORTERVILLE	SONOMA	TOTAL	
1	Office of Protective Services (OPS) responded immediately (within two hours) to the incident notification.	0	0	2†	2	47
2	The OPS first responder's narrative describes in detail what happened.	0	0	1	1	47
3	The OPS sergeant (or higher) approved the required report, indicating management review.	0	0	0	0	48
4	The OPS investigator interviewed or attempted to interview relevant parties.	0	0	9	9	47
5	The OPS investigative file includes written declarations from witnesses and suspects, as appropriate.	8	2	11	21	33
6	The OPS investigative file includes photographs of areas of injuries, regardless of whether an injury was evident.	8	1	10	19	38
7	For a sexual assault, a specialized medical examination of the alleged victim was completed as appropriate.	1	0	1	2	5
8	When applicable, OPS notified outside law enforcement of the incident.	0	0	0	0	2
	Totals	**17**	**3**	**34**	**54**	**267**

Sources: California State Auditor's analysis of OPS investigation files related to incidents that occurred between January 1, 2010, and December 31, 2012. We reviewed 16 investigative files each at the Fairview, Porterville, and Sonoma developmental centers, for a total of 48 investigative files.

* Some of the procedures listed above did not apply to all 48 incident investigations we reviewed. For example, if the incident was not a sexual assault case, investigative procedure 7 did not apply.

† For five OPS investigations at Sonoma, information on when OPS responded to health care staff's initial report of the incident was not received in forms we could review. Based on notes from Sonoma's OPS unit, one of these five responses was not within two hours. In another incident, OPS's response was within two hours and 45 minutes. Based on the circumstances, this response time appeared appropriate.

In 21 of the cases we reviewed, OPS's investigation files did not include written declarations from witnesses and the subjects of investigations, despite the appearance that such statements would have been relevant to the investigations. For example, in one case at Fairview, the OPS investigation file did not include written declarations from two staff members whom a resident accused of abusing him. The resident claimed he reported the abuse to another staff member that same night, but staff did not report the alleged abuse to OPS until 5 p.m. the next day. Because there were no witnesses to the alleged abuse, the investigation came down to a comparison of the client's claims to the denials of the accused staff members. OPS closed the investigation as inconclusive after interviewing those involved, but without obtaining written declarations from any of the staff members detailing their versions of what had occurred.

In nine cases we reviewed, all of which occurred at Sonoma, OPS did not interview all relevant parties during its investigations. Of particular concern, OPS sometimes did not interview alleged abuse victims. For example, in one case, a female staff member observed a male staff member committing a lewd act in close proximity to a female resident. A criminal investigation by local law enforcement substantiated that the male staff member committed a lewd act against the resident but local law enforcement dropped a related abuse charge. During its administrative investigation of the incident, OPS interviewed 60 staff members and residents but did not interview the victim and did not provide a valid explanation for not doing so.

For eight of these nine deficiencies at Sonoma, investigators stated that residents were nonverbal but did not document any further efforts using other means to communicate with those residents. In June 2012 OPS issued new policies that explain the potential for nonverbal residents to provide information to investigators. However, to make its recent policy changes more effective, OPS should further amend its policies to require investigators to document how they attempted to communicate with nonverbal residents. Although not every resident may be able to assist in investigations, due to a limited ability to communicate or a lack of awareness of his or her surroundings, we believe OPS should assume that residents who are alleged victims of abuse can be helpful in investigations until they establish evidence to the contrary.

In 19 cases we reviewed, OPS's investigation files did not include photographs of alleged victims' injuries.

In 19 cases we reviewed, OPS's investigation files did not include photographs of alleged victims' injuries. For example, Fairview OPS did not photograph the area of a resident's broken ribs during its investigation. The commander at the time informed us that the facility's medical staff satisfied the photography requirement by taking an X-ray of the injury. However, OPS policy does not

allow for it to delegate its photography responsibility to medical staff, and an X-ray does not provide the same visual information as a photograph. In another example, a Sonoma resident accused a staff member of punching him in the chest. The responding OPS officer did not find any evidence that an injury had occurred as the resident described, but the officer did not photograph the location of the alleged injury. Based on the simple OPS policy requirement, and because it would have strengthened support for the OPS officer's investigatory conclusion, we determined the OPS officer should have photographed the area of the alleged injury, regardless of whether the officer believed an injury had actually occurred.

OPS has a policy requiring specialized medical examinations for alleged victims of sexual assault, but our analysis of OPS cases from the last three years indicates that OPS did not always follow its policy.

OPS has a policy requiring specialized medical examinations for alleged victims of sexual assault, but our analysis of OPS cases from the last three years indicates that OPS did not always follow its policy. Specifically, in two of five applicable cases, OPS did not obtain specialized medical examinations for alleged victims of sexual assault, even though it appeared that examinations were warranted.[5] In a case at Fairview, a resident claimed to have been sexually abused by another resident, but OPS did not order a specialized medical examination. The abuser initially denied the accusation, but after OPS gathered additional corroborating evidence, confessed seven days later. At Sonoma, a male staff member confessed to law enforcement that he had inappropriate sexual contact with two female residents. However, this confession did not rule out the possibility that a specialized medical examination would have discovered evidence of more severe crimes against the two residents. Although the clinical staff of Fairview and Sonoma determined that specialized medical examinations were not necessary in these two cases, we believe that, for the victim at Fairview and at least one of the victims at Sonoma, department policy would require such an exam. In the case at Sonoma, neither the health care review record nor the OPS investigation record clearly indicates whether local law enforcement, OPS, or clinical staff made the final decision about whether an exam was necessary.[6] The fact that OPS also did not make a valid attempt to obtain victim testimony in this case further demonstrates the need for a specialized medical examination to determine whether more serious abuse occurred.

[5] We reviewed four additional investigations of alleged sexual abuse but agreed with the department's determinations that specialized medical examinations were not applicable in these situations because the questionable activity had been consensual between residents, had not actually been sexual in nature, or had allegedly occurred long enough in the past that an examination would not have been effective.

[6] According to the investigation report the Sonoma County Sheriff's Office prepared on this incident, the investigating detective agreed that the on-site physician could perform an initial examination of the alleged victim and then make a determination as to whether a forensic exam would be necessary. However, this report does not clearly indicate that the developmental center's physician actually made a final decision on this subject.

We could not always identify the causes for the shortcomings in OPS investigations. Because OPS leadership changed during 2012 at all three facilities we visited, the current commanders were not fully aware of OPS's past practices, particularly as they related to specific cases. However, we were told that in some cases OPS officers did not take photographs because they would have served no immediately apparent evidentiary purpose, and that OPS did not regularly collect witness declarations because, in other law enforcement environments, such statements are collected only from witnesses who can provide key eyewitness accounts of an incident. Nevertheless, OPS officers appeared not to have followed policy in these instances. Meanwhile, part of the failure to obtain specialized medical examinations for alleged victims of sexual assault appears to be confusion about who is responsible for ordering such an examination. For example, in one case we reviewed, the health care review report explained that the physician and OPS decided together that a specialized medical examination was unnecessary. Current OPS policy indicates that clinical physicians are responsible for making this decision, in consultation with OPS. However, the interim OPS chief stated that the department is currently drafting a revision to this policy that will make OPS responsible for determining whether an alleged victim of sexual abuse should receive a specialized examination. In addition, in May 2013 the department sent a memorandum to the executive directors and commanders of the developmental centers to clarify that OPS has the final determination on whether to send an alleged victim for a specialized medical examination, after consultation with the treating physician. However, this clarification has not yet been formalized in OPS's policies.

An OPS report on cases sent to district attorneys over the past three years suggests that district attorneys have frequently rejected OPS referrals for lack of evidence.

Finally, we also obtained a report from OPS on cases sent to district attorneys over the past three years. Although the report is incomplete, it suggests that district attorneys have frequently rejected OPS referrals for lack of evidence. The report does not indicate which of these rejections should be attributed to OPS shortcomings in collecting evidence and which should be attributed to an actual absence of necessary evidence. The department explained that district attorneys sometimes decline referrals from OPS because they view residents who would be essential witnesses as insufficiently reliable for the district attorneys to feel confident about successfully prosecuting those cases. In addition, the department told us that sufficient evidence of a crime for successful prosecution frequently does not exist after an incident—even in cases where OPS conducts a thorough and complete investigation. In other cases, such as in an example we reviewed at Porterville, shortcomings in OPS investigations may result in district attorneys rejecting OPS referrals. In the case from Porterville, the district attorney in Tulare County rejected a case that Porterville's OPS unit submitted in 2012 because, according to the district attorney, the OPS report lacked relevant descriptive information

about the suspect's developmental issues and the alleged victim's developmental issues, lacked any description of potential witnesses, and omitted facts that should have been gathered and reported from interviews during the investigation. OPS promptly conducted a follow-up investigation to gather the information the district attorney requested and resubmitted the case. This feedback from the district attorney illustrates the need for OPS to consistently conduct thorough investigations, so that district attorneys are able to prosecute abusers at the developmental centers.

The Department Is Addressing the Problem of Lengthy OPS Investigations

In June 2012 the department issued a policy requiring OPS to complete investigations within 30 days unless an investigator, after providing justification, receives approval for a timeline extension. Prior to this policy, OPS did not place a time limit on its investigations. As a result, OPS completed investigations within 30 days in only 15 of the 35 cases (43 percent) we reviewed that occurred before this policy change. In fact, three of these investigations took 292, 436, and 585 days, respectively, to complete.[7] Since the policy change, OPS has improved its timeliness, completing investigations within 30 days for nine of the 13 cases (69 percent) we reviewed that occurred subsequent to the change. Timely completion of these investigations is important in part because, according to the department's "zero-tolerance" policy, a staff member under investigation for possible resident abuse must be removed from resident contact and is not eligible to return to his or her regular duties until the investigation concludes.

An OPS commander explained that staff shortages, a large backlog of cases, and a lack of accountability contributed to untimely completion of investigations.

In reference to the cases that took many months to complete, the former OPS commander at Fairview (who is now the commander at the Lanterman Developmental Center) explained that staff performance is one factor, but he added that staff shortages and a large backlog of cases also contributed to the delays. He also indicated that, in the past, there was little to no accountability when investigations were not completed within acceptable time frames. We provide additional information regarding the backlog of OPS cases in Chapter 2. A department official explained that the OPS director currently uses monthly "commander reports" to view open investigations and discuss with commanders at each developmental center the barriers to completing their investigations in a timely manner. However, the department official acknowledged that, because of turnover in the OPS director and commander positions, there

[7] We note that our selection of cases was not random; we purposely selected a certain number of substantiated cases, which likely require more days to complete than unsubstantiated cases. Therefore, these results may not be representative of the timeliness of OPS investigations overall.

was a period of time in the past when this process did not occur. The department official added that OPS has reinstituted this process and will be conducting training for commanders on the need to collect and analyze data on any case backlogs. This appears to be a positive step in addressing an issue with which the department was already concerned.

The Department Has Attempted to Address Outdated and Inadequate OPS Policies, but Much Work Still Remains

We noted during our review that until recently, OPS did not appear to have regularly updated its policies and that existing policies do not provide sufficient guidance to its law enforcement personnel. A 2002 report from the Office of the Attorney General (attorney general), discussed in Appendix A, noted "a profound lack of written policies and procedures" within the Law Enforcement Division, the peacekeeping entity that later was reorganized as OPS.

Since its 2002 formation, OPS has developed various policies and procedures that address its law enforcement responsibilities. The current OPS manual consists of several sections developed in 1997 and 2001 for its predecessor, the Law Enforcement Division; a series of management memos from 2002 and 2003 written at about the time OPS was originally organized; and sections developed between 2007 and 2012 that address various aspects of OPS's work, including key organizational and investigative functions. The 2012 updates include detailed guidance for conducting administrative and criminal investigations, collecting evidence, advising interviewees of their rights before obtaining their statements, and performing interrogations.

Recent changes to investigative procedures in the OPS manual do not provide detailed direction on certain steps to take when collecting evidence at the scene of an incident.

Recent changes to investigative procedures that the department and OPS added to the manual in 2012 provide improved instruction on how to conduct some aspects of OPS investigations, such as collecting written declarations from staff, but do not provide detailed direction on certain steps to take when collecting evidence at the scene of an incident. For example, a policy added to the manual in June 2012 states that OPS should take photographs at crime scenes, but it does not say what should be photographed. This actually provides less direction than the policy it replaced, a 2008 policy that directed first responders to photograph injuries to residents. Moreover, the policy on collecting written declarations does not say whether OPS should be responsible for compelling these statements from staff, or whether it must go through developmental center managers to collect them. In addition, the new policies point out that nonverbal residents may be able to communicate through mechanisms besides speech. However, these policies do not direct investigators to document efforts made to communicate with nonverbal residents during investigations. If investigators do not take this step, end users of reports will

not know whether nonverbal residents who were alleged victims of abuse had the opportunity to provide their information and perspectives to law enforcement.

OPS's guidance on investigative reports does not require the report writer to document the specific violations of statutes or policies that may have occurred.

The department could benefit from adopting best practices from the California Highway Patrol's investigation guidelines. For example, we noted that OPS's guidance on investigative reports does not require the report writer to document the specific violations of statutes or policies that may have occurred. In the 48 OPS files we reviewed, we observed that nine did not identify the laws or policies the investigator considered during the investigation. In addition, six other files indicated that OPS investigated violations of developmental center policy, but did not indicate that the investigator considered any violations of law. The California Highway Patrol's field guide notes that a reference to the specific violations charged is a standard piece of information to be included in investigative reports. Without this information, OPS cannot be certain that its investigators have considered all potential administrative and criminal violations arising from incidents, or even know which policies and laws the investigator considered. The OPS acting chief agreed that it would be reasonable to have investigators include this information in their administrative and criminal investigation files.

According to the 2010 OPS policy, a staff member at headquarters is responsible for initiating an annual review of OPS policies to remove or update any that are outdated. In addition, a department official explained that since OPS's initial formation, the department has utilized outside expertise to provide additional insights and perspective. However, despite these efforts, we found and the department acknowledges that the OPS manual needs revision and expansion. The department explained that, to the degree it has not consistently maintained its efforts to update and improve the manual, the cause has been a lack of continuity in staff in key positions and the necessity for management to maintain focus on all aspects of the organization.

The department is working with law enforcement consultants to improve OPS's policies and procedures. These consultants prepared a comprehensive update of the OPS policy manual in October 2012 and informed the acting OPS chief that implementation would require a targeted effort by OPS to gain buy-in from its local units. Recently, the department has been working to implement this update. In May 2013 the department held a meeting with the OPS acting chief and the OPS commanders to review and finalize the manual. Prior to that meeting, the department had directed the commanders to review the manual with their local staff and submit recommended changes in advance. The deputy director of the Developmental Centers Division stated that the department estimates the new manual will be fully implemented as of June 2013.

OPS Policies for Collecting Written Statements During Incident Investigations May Create Risks

OPS policies could be strengthened in situations where the same investigator conducts an investigation of an incident that has the potential to involve both administrative and criminal aspects. These types of cases involve a difficult balance in which OPS investigators must ensure that they protect the rights of developmental center staff against self-incrimination while being diligent in their investigations. Judicial decisions have held that an employer may compel, under threat of termination, an employee to cooperate with an administrative investigation and can then terminate the employee for providing incriminating answers during that compelled testimony. However, such compelled testimony cannot be used against the employee in a related criminal proceeding. When appropriate, the department may compel its employees to provide such declarations for administrative investigations, and some centers' policies have delegated the responsibility for collecting these declarations to OPS. However, OPS policies note that declarations that centers require staff to provide as a condition of continued employment cannot be used in its criminal investigations.

This issue was addressed in the 2002 attorney general's report, discussed in Appendix A, which recommended that the administrative and criminal investigations for a given case be performed by different investigators. The report stated that when an incident has both criminal and administrative implications, the law enforcement industry standard is for two separate investigators to conduct two separate investigations. The report explains that this practice ensures the integrity of the criminal investigation by preventing the inadvertent contamination of the criminal investigation through the use of involuntary statements acquired through administrative admonishments. OPS policy recognizes this risk by requiring that in cases where simultaneous criminal and administrative investigations occur, administratively compelled statements cannot be considered in the criminal investigation. However, during our testing, we observed that in eight of the 48 cases we reviewed, the same OPS investigator conducted both the administrative and the criminal investigation, and then combined the results of these investigations into one final report. The department explained that because of staffing issues, a single investigator is in charge of a case if OPS needs to conduct both types of investigations. It further explained that until very recently, OPS separated investigations by conducting the criminal investigation first and the administrative investigation subsequently, with the findings captured in a single report. However, even if this sequence of investigations has been occurring, the department cannot be certain that the findings of the later investigation do not influence the findings of the initial investigation when the

In eight of the 48 cases we reviewed, the same OPS investigator conducted both the administrative and the criminal investigation, and then combined the results of the investigation into one final report.

results of both are combined in a single report. The department also noted that it is currently restructuring OPS, and it believes this restructuring will help OPS distinguish and separate the investigation processes.

Recommendations

The department should provide a reminder to staff about the importance of promptly notifying OPS of incidents involving resident safety.

Within 60 days, the department should make the following amendments to its policies and procedures for OPS:

- Clarify who is responsible for deciding whether to make district attorney referrals.
- Clarify that the final decision to initiate a specialized medical examination for an alleged victim of sexual assault rests with OPS, not with health care staff.
- Require OPS investigators to document their efforts to communicate with alleged victims of abuse, including nonverbal clients, and require supervisors to verify that such efforts have been made when approving investigation reports.
- Direct its investigators to record the potential violations of law or facility policy they identify and consider during each investigation.

To ensure adequate guidance to OPS personnel, once the department has amended OPS's policies and procedures to reflect the recommendations we have included here, the department and OPS should place a high priority on completing and implementing its planned updates to the OPS policy and procedure manual.

OPS should provide additional training to its law enforcement personnel on how to conduct an initial incident investigation, particularly regarding collection of written declarations and photographs of alleged victims following an incident.

To avoid jeopardizing the integrity of its criminal investigations with compelled statements acquired through administrative admonishments, the department should require that different OPS investigators conduct the administrative investigation and the criminal investigation when they involve the same incident.

Chapter 2

LONGSTANDING PROBLEMS IN THE OFFICE OF PROTECTIVE SERVICES HAVE NOT BEEN FULLY ADDRESSED, IN PART DUE TO A LACK OF CONTINUITY IN LEADERSHIP

Chapter Summary

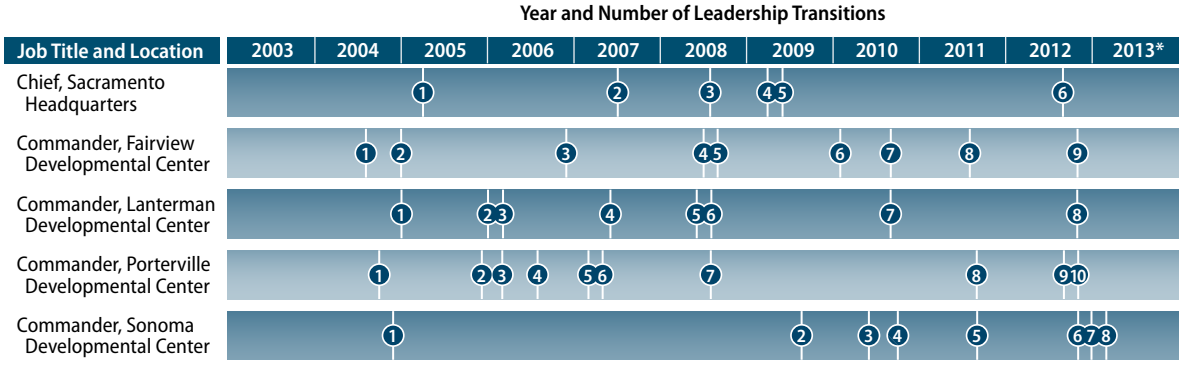
The California Department of Developmental Services (department) has experienced frequent changes in the leadership of its Office of Protective Services (OPS). This turnover has contributed to the department's inability to address problem areas, including the OPS investigative processes described in Chapter 1. In addition, OPS lacks specialized training to better equip its law enforcement personnel to work effectively within the developmental centers, and its recruitment practices for obtaining sufficient numbers of highly qualified peace officers and investigators are inadequate. Although the levels of compensation for OPS personnel are similar to those of staff performing comparable functions at other state agencies, the local police agencies with which the department's developmental centers must compete for staff often have higher levels of compensation. Another problem the department needs to address is the extensive use of overtime by department staff, including OPS staff. The use of overtime can be partially explained by staffing shortages due to budget cuts. However, the amount of overtime in some cases is excessive and could endanger staff and developmental center residents (residents). Finally, although the department is implementing a new system for collecting performance data for OPS, it lacks defined goals against which to measure the data and must improve the consistency of its developmental centers' use of this new data system.

OPS Has Experienced Frequent Changes in Its Leadership

Frequent changes in OPS leadership have made it difficult for the department to address a number of pressing issues. As a recipient of federal funds, the department is required to maintain processes to ensure compliance with applicable laws and requirements (internal controls). Our standards require us to examine the department's internal controls, including a review of whether management and employees have established a positive and supportive attitude toward these processes (control environment). One factor contributing to a positive control environment is the absence of excessive turnover among a department's key personnel. As shown in Figure 5 on the following page, leadership at OPS has changed frequently at the four developmental centers and at headquarters.

For example, the OPS chief has transitioned six times in the last 10 years. At the three developmental centers we visited, there were acting commanders at two—Fairview and Porterville—and the California Highway Patrol (CHP) had loaned OPS at the Sonoma Developmental Center (Sonoma) an employee to temporarily replace the previous commander, who was demoted in November 2012. Specifically, the department contracted with CHP in December 2012 for a CHP employee to oversee the daily operation of Sonoma's OPS. The department has also retained the services of two more CHP employees to continue providing these services through March 2014.

Figure 5
Leadership Changes in the Office of Protective Services



Sources: Report prepared by the California Department of Developmental Services (department) from various personnel records, including position history files, supplemented with email records and management memos.

Note: This figure reflects a leadership change each time a new individual began working in a leadership position, regardless of whether that person started in the position in a permanent, interim, acting, or other role. It does not reflect a change when the same individual transitioned from an interim or acting role to a permanent role in the same capacity and at the same facility. However, it does reflect a change when an individual moved from a leadership position at one location to a leadership position at another location.

* Through April 2013.

Turnover in leadership positions can result in new managers who may be unfamiliar with developmental center processes and management responsibilities within those processes. As noted in Chapter 1, we found numerous deficiencies in OPS investigations, at least some of which could have been avoided by a more consistent and effective review by OPS management at the centers. Chapter 1 also noted that the department acknowledged that turnover in OPS leadership caused the department to stop tracking, and discussing with OPS commanders, why certain investigations took a long time to complete. Further, a lack of consistent leadership at OPS likely contributed to the incomplete and outdated policies we discussed in Chapter 1. In the sections that follow, we outline other deficiencies related to training and recruitment of staff, as well as monitoring of overtime. OPS will likely continue to struggle with these problems until it can establish stability in its key leadership positions.

Although OPS Minimum Required Training Complies With Regulations, OPS Does Not Regularly Provide or Require Specialized Training

The OPS training policy for its law enforcement personnel includes all requirements of the Commission on Peace Officer Standards and Training (commission), which sets the minimum selection and training standards for California law enforcement. In addition, commission records show that OPS law enforcement personnel met all training and certification requirements, and all but three personnel met continuing education requirements.[8] Even so, OPS is not fully addressing the additional training needs of its law enforcement staff as they relate to duties and interaction with residents.

OPS is not fully addressing the additional specialized training needs of its law enforcement staff as they relate to duties and interaction with residents.

A 2002 report from the Office of the Attorney General (attorney general), discussed in Appendix A, recommended that OPS develop a training program that offers specialized courses relevant to law enforcement within a clinical environment. However, only recently has OPS provided additional training for its law enforcement personnel; specifically, the department provided report-writing classes in January 2012, an investigative procedures update in June 2012, and sexual assault training in fall 2012. We examined comparable training programs at the California Department of State Hospitals (State Hospitals), the California Department of Corrections and Rehabilitation (Corrections), and the California Department of Social Services (Social Services) and found that two of these agencies provide specific training beyond commission requirements. State Hospitals not only requires commission-mandated and general hospital orientation training, but also requires its newly hired officers and investigators to complete a collection of approved in-service trainings that include police response in a psychiatric environment. Likewise, Corrections not only requires its investigators to take commission-mandated classes, but also provides additional in-house training that includes classes on "advanced investigation." Social Services does not require a specific set of additional trainings but has its investigators and their supervisors prepare an annual training plan designed to ensure that investigators obtain training related to the specific fields and populations they will encounter.

Table 6 on the following page lists the initial training required and in some instances recommended for OPS law enforcement personnel. It also lists the additional training we believe, based on our review of OPS investigations (described in Chapter 1), the department should develop and annually provide to OPS law enforcement personnel.

[8] Three of 92 OPS law enforcement personnel did not meet their continuing education requirements for the 2011 and 2012 two-year training cycle. The department's training coordinator explained that one of these instances related to a maternity leave, another involved a sudden change in position near the end of the two-year cycle, and the final instance occurred because an investigator was pulled from required training to complete an investigation.

Table 6
Training for California Department of Developmental Services' Law Enforcement Staff

TRAINING OCCURRENCE AND STAFF IT APPLIES TO	EXISTING AND RECOMMENDED TRAINING
Initial training required for peace officers and investigators	Regular Basic Course* mandated by the Peace Officer Standards and Training Commission, which includes the following classes, among others (required number of instruction hours): • Investigative report writing (52 hours) • Policing in the community (18 hours) • Crime scenes, evidence, and forensics (12 hours) • Search and seizure (12 hours) • Crimes against persons (6 hours) • People with disabilities (6 hours) • Presentation of evidence (6 hours) • Crimes against children (4 hours) • Sex crimes (4 hours)
Initial training required for investigators and recommended for peace officers	• Child abuse investigation • Sexual assault investigation
Annual training we recommend the California Department of Developmental Services (department) develop and provide to both peace officers and investigators	• Interacting with developmental center residents • Collecting evidence • Writing clear and effective investigative reports

Source: California State Auditor's analysis of the department's policies.

* Includes 43 classes, only some of which are listed in this table, and 560 hours of instruction that are taken by all Office of Protective Services' law enforcement personnel. Also, investigators can substitute a Specialized Investigator Basic Course, which has almost all of the same classes as the regular Basic Course, including those listed.

As shown in Table 6, department policy requires only OPS investigators to take commission trainings relevant to certain investigation duties, including sexual assault and child abuse investigation trainings. Department policy recommends, but does not require, that its peace officers attend these same trainings. The department explained that it does not require such investigative training of its peace officers because not all of these officers are expected to be assigned job duties that necessitate this type of training. However, according to OPS's "Peace Officer—First Responder Duties" policy, it is the responding officer's duty to perform the preliminary investigation of the reported incident. If the responding peace officer has not taken training relevant to the reported incident, such as a sexual assault, the officer might not competently perform the preliminary investigation.

As noted in Chapter 1, OPS law enforcement, which includes first responders, failed to follow policies and procedures for investigations in a number of critical areas. For example, the Sonoma OPS law enforcement personnel did not always attempt to communicate with the alleged victims of harm, particularly those who were nonverbal but may have been able to communicate through other means. The department requires newly hired OPS personnel to attend an orientation at each developmental center, and this orientation includes instruction on how to interact with residents. However, this instruction varies

among centers and is not specifically designed for the types of resident interactions—victim, suspect, and witness testimony—that OPS's specialized duties require. Consequently, we believe annual training is necessary in which OPS management reemphasizes policies and procedures and in which OPS personnel practice communication techniques.

In Chapter 1 we also noted a number of deficiencies in the collection of investigatory evidence, including a failure to take photographs, to obtain written declarations from witnesses and suspects, and to request a specialized medical exam for sexual assault cases. In June 2012 the department had law enforcement consultants provide training in conjunction with an update of OPS's policies regarding investigations. In addition, during October and November of 2012, OPS law enforcement personnel participated in an online commission training on responses to and investigations of sexual assault. Although these were positive steps, the department should, on at least an annual basis, require OPS management to provide training on revised investigatory policies or other best practices. This type of training would provide OPS management an opportunity to reemphasize existing standards and allow innovative techniques to spread across the different developmental centers.

In January 2013 CHP personnel provided additional training in investigative report writing to Sonoma OPS. These personnel had assessed Sonoma's OPS performance and identified, as one of their concerns, problems with the quality of investigative reports. Specifically, CHP noted issues such as lax proofreading, lack of evidence included in reports, and the lack of follow-up interviews. Considering how critical investigative reports are to the performance of OPS duties, we believe that annual training on writing clear and effective investigative reports is necessary. Together with the annual training in investigatory policies, procedures, and communication with residents described earlier, this training will help OPS law enforcement to better complete high-quality investigative reports, which will in turn help ensure that residents are protected. Rather than have this annual training provided by outside consultants, we believe the department could further develop OPS leadership by having its management develop and provide this training, particularly when the emphasis of the training is implementing existing OPS policies.

Considering how critical investigative reports are to the performance of OPS duties, we believe that OPS should offer annual training on writing clear and effective investigative reports.

Although OPS's Hiring Process and Minimum Qualifications Follow State Requirements, It Lacks a Formal Recruitment Program

In its hiring of OPS law enforcement personnel, the department meets the commission's minimum qualification requirements for peace officers and must follow the civil service selection process outlined by the State Personnel Board in its *Merit Selection Manual*.

However, OPS does not currently have a formal recruitment plan, and its informal recruitment efforts have been negligible. Recruiting difficulty has been a persistent problem and was cited in the 2002 attorney general's report, which stated that recruitment of well-qualified personnel was a serious issue for OPS's predecessor and recommended that it pursue all means available to recruit the most highly qualified personnel. The *Merit Selection Manual* states that the recruitment process is intended to attract a sufficient number of qualified applicants and recommends that agencies develop an annual schedule that includes a variety of recruitment venues, including college campuses, job fairs, and workshops.

According to the interim OPS chief, before 2007, staff used to visit colleges, academies, and career fairs to recruit, but due to a lack of funding and staff, they now only post job announcements. He added that each OPS located at the various developmental centers performs its own recruitment efforts. We spoke with OPS located at the Fairview, Porterville, and Sonoma developmental centers, and—similar to the statement made by the interim chief—they indicated that they have not participated in any recruitment activities in the last four to five years. Table 7 shows that, in fiscal year 2011–12, OPS had a vacancy rate of 42.8 percent in its law enforcement positions. Although OPS officials pointed to hiring limitations associated with budget reductions, the number of OPS vacancies indicates a staffing problem that, if it is going to be resolved, will require better ongoing recruitment efforts. In May 2013 the department took steps to address its recruitment needs by entering into an agreement with a consultant to conduct outreach efforts, advise the department of effective recruitment methods, and design a recruitment plan to find high-quality OPS candidates.

Table 7
Law Enforcement Positions at the Office of Protective Services
Fiscal Year 2011–12

			AUTHORIZED POSITIONS NOT FILLED	
LOCATION	AUTHORIZED	FILLED	AMOUNT	PERCENTAGE
California Department of Developmental Services, Headquarters (department)*	3	2.2	0.8	26.7%
Canyon Springs Community Facility	6	5.5	0.5	8.3
Fairview Developmental Center	21	7.7	13.3	63.3
Lanterman Developmental Center	16	7	9	56.3
Porterville Developmental Center	77.9	50.9	27	34.7
Sonoma Developmental Center*	23	10.8	12.2	53.0
Totals	**146.9**	**84.1**	**62.8**	**42.8%**

Source: California Department of Finance's Fiscal Year 2012–13 and 2013–14 Salaries and Wages reports.

* Six of the Sonoma Developmental Center's authorized investigator positions are assigned to the professional standards branch at department headquarters.

OPS Compensation Is Similar to That of Comparable State Agencies But Is Often Less Than Local Law Enforcement Agencies

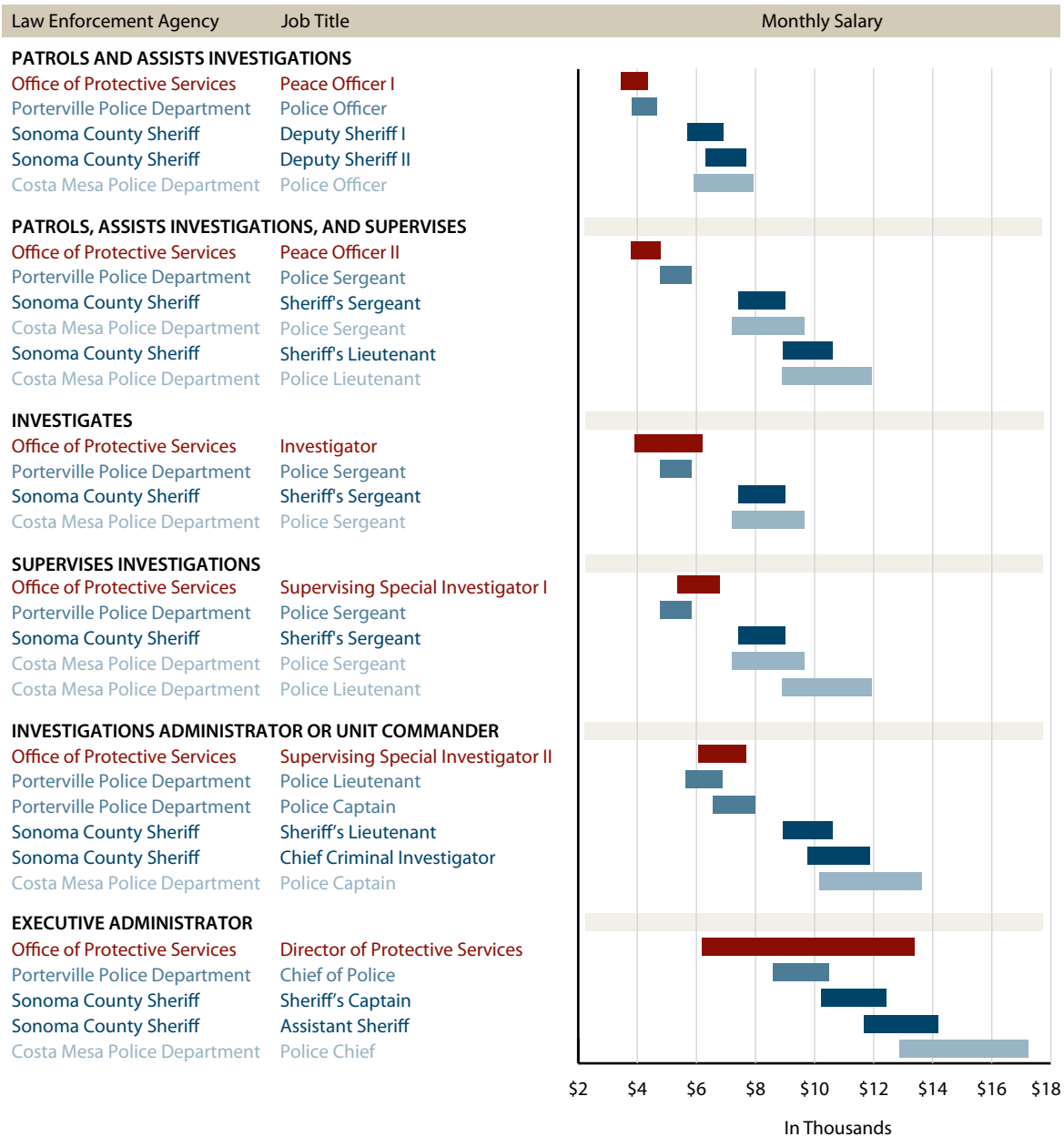
Compensation for OPS law enforcement employees is similar to that of employees in comparable positions at a selection of state agencies. However, these employees are generally paid less than officers of local law enforcement agencies within close proximity to the Sonoma, Fairview, and Porterville developmental centers.

We compared OPS law enforcement compensation, including salary and benefits, to the compensation paid by State Hospitals, Corrections and Social Services, as well as local law enforcement agencies. The benefits we examined included medical, dental, vision, life insurance, and retirement. The compensation for law enforcement positions at State Hospitals and Social Services was similar to that for OPS law enforcement positions. For example, State Hospitals' entry-level police officer and the department's entry-level peace officer have the same salary range of $3,455 to $4,360 per month. Also, State Hospitals' and Social Services' supervising special investigators start at $5,369 per month, which is the same as OPS's starting salary for that position. Corrections' salaries were generally higher than those for OPS, State Hospitals, and Social Services. For example, the entry-level pay range for Corrections' special agent classification, which performs investigations, is $6,258 to $8,450 per month. Although Corrections has law enforcement personnel with a lower starting salary than its special agents, these other positions do not perform the investigative duties expected of OPS's law enforcement staff. However, the starting special agent position for Corrections requires a minimum of five years of investigative experience, unlike the entry-level law enforcement positions at OPS, State Hospitals, and Social Services.

We also compared OPS compensation with the compensation of law enforcement personnel at the Sonoma County Sheriff's Office, the Costa Mesa Police Department (located near Fairview), and the Porterville Police Department, due to their close proximity to the developmental centers we visited. As shown in Figure 6 on the following page, OPS law enforcement compensation was generally less than the compensation for these local police agencies, with the Porterville Police Department's compensation being the most similar. At the executive administrator level, the pay scale of the OPS director position starts lower than comparable positions but has a higher top end than some of these positions.

The benefits provided by OPS and the nearby local law enforcement agencies varied but overall were roughly equivalent. Consequently, in the instances shown in Figure 6 on the following page in which OPS salaries are significantly lower than the local law enforcement agencies, it would be reasonable to expect that OPS would have some difficulty competing for qualified applicants.

Figure 6
Salary Scale Comparison of the Office of Protective Services and Local Law Enforcement Agencies, Grouped by Job Duties



Sources: California State Auditor's analysis of job duties and monthly salaries from the California Department of Human Resources' civil service pay scales, County of Sonoma Human Resources Department Job Descriptions/Salaries Web site, City of Costa Mesa Police Department Web site, and the County of Porterville Position Pay Plan.

The 2002 report commissioned by the attorney general found that the salary structure for the department's law enforcement personnel was far below comparable positions in the surrounding geographic areas of the developmental centers. To address this issue, the report recommended that the department establish

equivalency in salary and benefits with police at the University of California and California State University. The department stated that such an equivalency has not been established because the process for state departments to address employee compensation issues involves collaboration with the California Department of Human Resources (Human Resources), which is responsible for negotiating with collective bargaining units representing these law enforcement personnel to establish any compensation changes. According to the department, it does not currently have a proposal with Human Resources to address OPS salaries because it was previously unsuccessful in doing so and, due to the State's longstanding fiscal crisis, the possibility of success is remote.

According to the department, it does not currently have a proposal with Human Resources to address OPS salaries because it was previously unsuccessful in doing so due to the State's longstanding fiscal crisis.

Developmental Centers Have Allowed Some Employees to Work Excessive Amounts of Overtime, Which May Compromise the Health and Safety of Other Staff and Residents

Despite research showing the risks associated with working long hours, the developmental centers allow some employees to continually work excessive amounts of overtime, which may compromise the health and safety of other staff and residents. A 2012 study published in *Health Affairs* examined the relationship between nurses' working hours and various patient outcomes. The authors of the study concluded that their findings contribute to a growing body of research associating nurses' shift length with patient safety issues. In the article, the authors state that at a minimum, hospital administrators should establish practices designed to comply with the Institute of Medicine's recommendation to limit nurses' work hours to 12 hours in a 24-hour period and to 60 hours in a week. This is consistent with previous studies published by *Health Affairs* in 2004 and by *The American Journal of Critical Care* in 2006, stating that both errors and near errors are more likely to occur when nurses work 12 or more consecutive hours. We believe it is reasonable to presume that such results could apply to other health care staff as well, such as psychiatric technician assistants. Additionally, a 2012 National Institute of Justice article on officer work hours, stress, and fatigue reports excessive overtime as one factor that can cause law enforcement officers not to perform their jobs effectively. This article also states that fatigue can harm an officer's mental health by impairing judgment and decreasing an officer's adaptability to certain situations, a condition that could put residents at risk.

The State's rank-and-file civil service employees are divided into 21 bargaining units, each covered by agreements that spell out the terms and conditions of their employment, including overtime provisions. Unions represent each bargaining unit and negotiate the terms of a new agreement directly with Human Resources,

which represents the executive branch of state government in these negotiations. These agreements are not final until they are approved by union members, ratified by the Legislature, and signed by the governor.

Although bargaining unit agreements for registered nurses, psychiatric technicians, and peace officers limit the use of mandatory overtime at the developmental centers, they do not limit the amount of voluntary overtime that employees can work.

Although bargaining unit agreements for registered nurses, psychiatric technicians, and peace officers limit the use of mandatory overtime at the developmental centers, they do not limit the amount of voluntary overtime that employees can work. Bargaining unit agreements and developmental center policies generally give preference to voluntary overtime, and the centers have not set a cap on the amount of voluntary overtime an employee may work, other than setting a daily maximum of 16 hours of work in a 24-hour period. In addition, they do not have a process to ensure that voluntary overtime hours are distributed evenly among staff.

In a 2009 audit report, *High Risk Update—State Overtime Costs*, the State Auditor identified some department employees working significant amounts of overtime. In the 2009 report we recommended that the department encourage Human Resources' predecessor to include a provision in future collective agreements to cap the number of voluntary overtime hours an employee can work and to require the developmental centers to ensure that overtime hours are distributed more evenly among staff.

In response to the 2009 audit report, the department stated that it monitors staffing hours within its developmental centers, and in an effort to nullify potential health and safety risks, line supervisors evaluate on a daily basis staff's ability to perform their duties and have the authority to make adjustments accordingly. We did not find written procedures for how supervisors evaluate the ability of staff working overtime to perform their duties; however, the deputy director of the Developmental Centers Division explained that management generally checks for staff alertness and skill during a meeting of employees starting a shift and also while observing them doing their regular rounds during the shift. The deputy director explained that this evaluation is based on subjective assessment of the supervisors and that more formal procedures would not change the fundamental need for supervisors to exercise good judgment in allowing an employee to work overtime. A department official added that the department cannot change how it administers overtime, such as adding a cap or otherwise distributing overtime hours, without changing the bargaining unit agreements.

As shown in Appendix B, Table B.1 on page 73, the department spent nearly $29 million on overtime pay and nearly $281 million on its employees' regular pay in 2012. Overall, the department's overtime pay as a percent of total earnings was very similar to the

amounts spent at State Hospitals and Corrections. However, the department's Peace Officer I class title had the highest average overtime as a percent of total earnings compared to similar class titles in comparable departments. As shown in Appendix B, Table B.2 on page 74, overtime pay earned by Peace Officer I employees accounted for 33 percent of these employees' total earnings in 2012. As indicated in Appendix B, Figure B on page 75, over the past two years the department appears to have addressed some of the excessive overtime within OPS.

Nonetheless, payroll data from the California State Controller's Office showed that during the five-year period from 2008 through 2012, 62 health care and OPS law enforcement employees were paid at least the same amount of overtime as regular pay. These 62 employees were paid nearly $11.4 million in regular pay and $14.1 million in overtime pay for the period. As shown in Table 8, of these 62 employees, 51 are health care staff, 10 are law enforcement staff, and one is a security guard.

Table 8
Amounts Paid to 62 California Department of Developmental Services Employees Who at Least Doubled Their Pay With Overtime by Job Classification From 2008 Through 2012

JOB CLASSIFICATION/CLASS TITLE	TOTAL REGULAR PAY	TOTAL OVERTIME PAY	NUMBER OF EMPLOYEES PAID AT LEAST THE SAME AMOUNT IN OVERTIME AS REGULAR PAY
Law Enforcement and Security			
Peace Officer I	$1,630,969	$2,003,691	8
Peace Officer II	361,909	399,508	2
Security Guard*	79,179	85,861	1
Health Care			
Psychiatric Technician Assistant	5,057,445	6,335,444	34
Psychiatric Technician	3,653,608	4,508,370	15
Registered Nurse	159,091	193,426	1
Health Services Specialist	457,349	571,089	1
Totals	**$11,399,550**	**$14,097,389**	**62**

Sources: California State Auditor's analysis of payroll data maintained by the California State Controller's Office and the California Department of Human Resources' Civil Service Pay Scales data.

Note: For instances where employees held multiple class titles during our audit period, the totals presented combine the employee's pay for all positions held, and the position presented is the class title with the highest salary held by the employee. This analysis includes the California Department of Developmental Services' (department) employees who worked six months or more and were paid at least $10,000 in regular pay during the period from 2008 through 2012.

* In the past, security guards staffed the towers around the Porterville Developmental Center's secure treatment program area. However, the department eliminated all of these positions in 2010 and now uses cameras to monitor the secure area.

Some health care and law enforcement employees volunteer to work excessive amounts of overtime, while other employees work minimal or no overtime. As shown in Table 9, of all health care and law enforcement employees, eight were paid overtime equal to 150 percent or more of their regular pay. Further, these eight employees work in positions related to resident safety and often averaged more than 70 work hours per week in the five-year period we reviewed. One of these eight employees, a peace officer, worked an average of 102 hours per week, every week, in 2008. According to the overtime studies mentioned previously, working this many hours puts the safety of developmental center staff and residents at risk.

Table 9
Average Weekly Hours Worked by Eight California Department of Developmental Services Employees Paid at Least 150 Percent of Their Regular Pay in Overtime From 2008 Through 2012

CLASS TITLE	DEVELOPMENTAL CENTER WHERE EMPLOYEE WAS PAID	AVERAGE NUMBER OF HOURS WORKED PER WEEK*					TOTAL REGULAR PAY	TOTAL OVERTIME PAY
		2008	2009	2010	2011	2012		
Psychiatric Technician Assistant	Sonoma	54	83	69	72	77	$84,755	$164,386
Psychiatric Technician Assistant	Sonoma	44	98	72	88	79	129,508	223,471
Psychiatric Technician Assistant	Sonoma	81	70	69	100	99	170,940	290,398
Psychiatric Technician†	Sonoma	70	64	86	90	90	220,467	365,568
Peace Officer I	Porterville‡	102	81	86	81	64	278,789	460,661
Psychiatric Technician Assistant	Sonoma	83	82	81	77	79	170,545	265,631
Peace Officer I	Porterville	92	74	72	–	–	137,044	208,275
Psychiatric Technician Assistant	Sonoma	73	75	88	79	77	165,779	248,310

Sources: California State Auditor's analysis of payroll and leave accounting data maintained by the California State Controller's Office and the California Department of Human Resources' Civil Service Pay Scales data.

Note: Six of the eight employees included in this table have accrued compensating time off in lieu of receiving paid overtime. Specifically, one employee accrued 696 hours of compensating time off. The other five employees accrued compensating time off hours ranging from 14 to 144 hours from 2008 through 2012.

This analysis includes the California Department of Developmental Services' employees who worked six months or more and earned at least $10,000 in regular pay from 2008 through 2012.

* We calculated the average number of hours worked per week by adding the average weekly number of overtime hours paid to an assumed standard 40-hour work week.

† During the period from 2008 through 2012, the employee also held the class titles Pre-Licensed Psychiatric Technician and Psychiatric Technician Assistant. We included information related to all three positions when calculating the average number of hours worked per week, total regular and overtime pay amounts, and total compensating time off hours.

‡ During June and July 2008, the employee received regular pay from both the Fairview and Porterville developmental centers. We included both developmental centers when calculating the average number of hours worked per week, total regular and overtime pay amounts, and total compensating time off hours.

The department stated that some staff work significant amounts of overtime because the developmental centers need to meet internal staffing requirements, and the same staff frequently volunteer for the assignments. The centers determine the need for their staff to work overtime based on minimum staffing guidelines and individual

resident's needs. Developmental center staff and management review and determine staffing needs on a daily basis to ensure that residents receive appropriate care and supervision. Additionally, centers have policies to provide increased observation, such as one-on-one observation by clinical staff if a resident displays a risk of self-injurious or assaultive behavior, medical problems that require frequent monitoring, or a decreased ability to protect himself or herself from harm by others. However, the department stated that staff members required for one-on-one observations are not included in the department's authorized positions approved by the California Department of Finance because the department's approved budget methodology does not account for such staff. Consequently, the department often does not have existing staff to fulfill these one-on-one observation assignments.

The commander at Porterville stated that the OPS unit is short staffed and some employees continue to volunteer to work overtime while others prefer little to no overtime. He added that, to avoid a potential union issue, the scheduling officer will always accept volunteers before mandating overtime. Sonoma's clinical director stated that some health care staff work significant amounts of overtime by volunteering between multiple programs within a facility. She explained that management in one program do not necessarily monitor overtime an employee works in another program. Without resolving these scheduling and staffing issues, and without any further restrictions on the amount of overtime an employee can work, the department risks continuing to allow some employees to work excessive amounts of overtime, thus putting resident safety at risk.

Without resolving scheduling and staffing issues and without any further restrictions on the amount of overtime an employee can work, the department is putting resident safety at risk.

Developmental Centers Had Some Overtime Without Written Approval and Mistakenly Paid Some Overtime at Premium Levels

In our review of overtime policies and practices at the Fairview, Porterville, and Sonoma developmental centers, we identified some instances of overtime without preauthorization and post-certification signatures approving the overtime, and a few errors in the calculation of overtime payments. Although nurses' and law enforcement personnel's bargaining unit agreements require supervisors to preauthorize overtime, the agreements appear to allow these authorizations to be verbal. The department confirmed this and stated that preapproval is often verbal for psychiatric technicians as well. However, the department also stated that retroactive written approval is obtained for overtime worked by nurses and psychiatric technicians. Additionally, the bargaining unit agreement for law enforcement personnel requires that overtime authorization be confirmed in writing. Further, at the three developmental centers we visited, the form used to document

the amount of, and reason for, overtime requires a signature to authorize the overtime and another signature to certify that extra hours were worked.

Also, the bargaining unit agreements for nurses, psychiatric technicians, and law enforcement personnel specify rules for whether overtime is paid at the employee's regular hourly rate or at a premium rate of 1.5 times the employee's hourly rate. For example, these agreements state that if an employee is mandated to work overtime in the same work week in which he or she uses approved leave, that approved leave (except sick leave) will be considered hours worked for purposes of calculating an overtime premium. However, if overtime is voluntary, leave time shall not be considered as time worked by the employee for the purpose of determining whether an employee's overtime should be paid at the premium rate.

During our review of 30 instances of overtime from 2010 through 2012 at Fairview, Porterville, and Sonoma, it was often not possible for us to determine whether overtime authorization occurred prior to overtime hours being worked. Based strictly on whether a supervisor signed the authorization line on the overtime form, we found 11 instances where this part of the form was blank or the developmental center could not find the overtime form. Additionally, we found four instances where the line on the form for certifying with a signature that the overtime was worked was blank, or had a signature but no date. Despite these omissions, the centers' human resources paid the overtime.

We also found three instances in which human resources did not correctly calculate the overtime compensation, resulting in almost $240 in overpayments to the employees. These overpayments occurred because human resources counted holiday credit or sick leave as time worked for the purpose of calculating payments for voluntary overtime, even though this practice is prohibited under the terms of the respective employees' bargaining unit agreements. At the time of our review, Sonoma and Porterville did not require staff to fill out their overtime hours on the State's standard absence and additional time worked form. This form includes leave as well as overtime, and may have prevented the errors we found.

We found that the human resources specialists at the centers do not have specific procedures or checklists for determining the rate of overtime pay.

The human resources managers at these developmental centers generally attributed the mistakes to human error. We found that the human resources specialists at the centers do not have specific procedures or checklists for determining the rate of overtime pay. The human resources director at Sonoma stated that human resources staff are trained to know the steps to determine the overtime pay rates based on the bargaining contracts, side letters, and governor's directives. As a result of the overtime payment

errors we found, in May 2013 the department directed centers to have staff use the absence and additional time worked form. We found this form to be more effective than other forms being used at some centers because it includes both time off and extra time worked, both of which are needed for determining overtime pay rates. Additionally, two of the three centers we visited provided training on leave and overtime documentation standards to their human resources staff, and the third initiated a specific method of monitoring to ensure accurate reporting of time worked and processing of payroll. According to human resources staff at the centers where we found these overpayments, they have begun the process to recoup the overpayments.

The Department Tracks Some Performance Data for OPS, but to Realize the Value of This Data, It Needs to Define Performance Goals

A 2002 attorney general's report, discussed in Appendix A, recommended that the department establish goals for OPS and implement a system to measure OPS performance relative to these goals. Best practices in law enforcement suggest that police departments are more effective when they use performance measures to determine the extent to which they are meeting standards and achieving goals. We found that the department and OPS have taken steps toward using performance measures to improve safety outcomes for residents and implemented a new department-wide incident tracking system in 2012. However, the department has not established short- or long-term goals for OPS that would allow the department to use the data it is collecting to compare OPS's performance to expectations the department has clearly defined and communicated. As the department further develops its ability to use data, we suggest specific data analyses that the department could develop later in this chapter, but we caution that it needs to improve the consistency of data collection among the various developmental centers.

The department has not established short- or long-term goals for OPS that would allow it to use the data it is collecting to compare OPS's performance to expectations it has clearly defined and communicated.

The Department and Local OPS Units Track Some Performance Data but Have Not Defined Goals Against Which to Measure This Data

Federal guidance suggests that performance standards and measures are useful to establish a positive control environment—one in which upper management encourages compliance with applicable requirements. Specifically, the guidance states that management should have effective procedures for monitoring the results of delegating authority and responsibility, and suggests that agencies establish and monitor performance measures. The department regularly tracks OPS's open case backlog and its overtime usage. It implemented a new data system in 2012, known as the Incident

Reporting Information System (IRIS), that it is using to collect information about incidents. This system holds promise for developing statistics about OPS performance that will allow the department to track trends in investigation duration and results over time. We discuss IRIS more fully in the next section of this chapter.

When we asked the commanders of the individual OPS units what standards they are using to measure their performance, we were told that commanders use differing performance standards and measures. The acting commander of the Fairview Developmental Center told us that he reviews and tracks each incident report and investigation, as opposed to keeping aggregate statistics. Porterville Developmental Center's (Porterville) acting commander told us that he reviews a monthly report of closed cases to track his force's effectiveness, and said that he is aware that his unit has a backlog of more than 100 investigations to complete. As indicated in the text box, Porterville appeared to have the largest backlog of investigative cases of the three centers we visited. In addition to tracking uncompleted investigations, the department demonstrated that it uses reports on overtime usage and case openings and closures to review and monitor OPS's performance. However, in both instances, we did not identify goals against which the department measures this information to determine whether OPS has achieved specific performance outcomes. If the department does not consistently use predetermined performance goals against which to evaluate OPS's performance, it cannot be certain that OPS is consistently and efficiently completing its responsibilities. Accordingly, the department should identify measurable indicators of OPS's effectiveness, set goals related to those indicators, and assign someone the responsibility of tracking such indicators over time.

Uncompleted Investigations at the Three Developmental Centers We Visited March 2013

Fairview: 37 (0 cases from past fiscal years)

Porterville: 156 (101 cases from past fiscal years)

Sonoma: 81 (13 cases from past fiscal years)

Source: California Department of Developmental Services' March 2013 summary report of outstanding Office of Protective Services' cases.

We provide examples of information the department could analyze for this purpose in the text box on the following page. For example, the department could identify methods for measuring the quality of OPS investigations by identifying expected elements of a complete investigation, as we have done in Chapter 1. The department could regularly review OPS investigations to see whether those expectations are met, and establish measures and goals to continue to improve. The department could use this information to focus OPS training on areas where OPS needs to improve. Doing so would improve the likelihood that OPS's investigations will consistently contain all the information department management and district attorneys need to make crucial decisions affecting resident safety.

Developmental Centers Have Inconsistent Methodologies for Tracking Alleged Resident Abuse

The ability of the department to use performance measures can be inhibited by the developmental centers' practices for tracking allegations of resident abuse. For most of the past five years, from 2008 to 2012, each of the three centers we visited had its own methodology and data system for tracking cases of resident abuse. Consequently, they did not always track the same information relating to these cases. Even after implementation of a new department-wide data system in 2012, the centers still did not track resident abuse data consistently.

Before November 2012 Sonoma tracked allegations of resident abuse through a data system called New Incident Report Management Analysis (NIRMA). However, Sonoma did not track within NIRMA the OPS case numbers or dispositions related to incidents. Porterville tracked allegations of abuse with a data system called Risk Management Database (RMD). However, Porterville did not accurately track within RMD whether an injury was related to abuse, substantiated cases of abuse, or cases it sent to the district attorney.

Examples of Information the California Department of Developmental Services (Department) Could Use in Setting Goals for the Office of Protective Services (OPS) and Measuring OPS's Effectiveness

The department should consider using the following types of information as the bases for establishing performance goals for its OPS:

- Availability of OPS resources to respond to incidents and efficiently complete investigations.
- Timeliness of OPS response to incident locations.
- Timely completion of OPS investigations.
- Quality and completeness of investigations.

Source: California State Auditor's analysis of OPS's responsibilities and the information the department gathers or plans to gather related to incident reviews and investigations.

As of February 2013 the developmental centers we visited changed their policies for determining whether to generate an incident report for an allegation of abuse. The department's policy states that in order to protect residents from abuse, centers are to document and track any incident or unusual occurrence involving a resident; this includes any inappropriate contact, motion, or action involving a resident by anyone, including staff and other residents. Before February 2013 the centers we visited did not generate incident reports for resident-to-resident altercations that did not involve an injury.

A department official stated that the department has had challenges in reaching a consensus about reporting resident-to-resident altercations as abuse. She also stated that the department is unable to retrace any specific discussion about the interpretation but understands that there are instances in which contact may have occurred between residents that do not call for an incident report. As of February 2013 the developmental centers we visited revised their incident-reporting policies to require an incident report for all resident-to-resident altercations, regardless of injury.

In June 2012 the department began implementing a new department-wide data system, IRIS, for tracking all incidents, including cases of resident abuse. A department official stated that IRIS allows the department to collectively track in real time all incidents of abuse at its developmental centers. However, based on the IRIS data we gathered, the centers are not consistently using IRIS's available data fields. For example, Sonoma does not consistently track resident abuse incidents investigated by OPS or their disposition within IRIS. Sonoma's quality assurance director stated that Sonoma does not use these data fields because it does not have time to fully train staff due to the extended licensing reviews performed by the California Department of Public Health, and because OPS was in transition during the training periods for IRIS.

Additionally, Porterville continues to use its former incident-tracking database while simultaneously using IRIS by entering the same incident data into each system. Porterville's standards compliance coordinator stated that management continues to track incidents with the former system because of data limitations and other difficulties with IRIS. For example, the standards compliance coordinator stated that IRIS does not allow the developmental center's management to customize reports or trend incident data to the extent that the former system does. According to a department official at the department's headquarters in Sacramento, the department is still transitioning to the reporting capabilities of IRIS and is still developing the tracking and trending procedures.

Although the department has implemented a uniform data system to globally track resident-related incidents, it has not ensured that its centers are using the system consistently.

Because the developmental centers are not consistent in their recording of incident data into IRIS, the department cannot effectively use the data for performance metrics or adequately analyze the causes or trends associated with resident abuse. Although the department has implemented a uniform data system to globally track resident-related incidents, it has not ensured that its centers are using the system consistently, which has resulted in some centers not using some of the system's important data fields. To allow for the creation of consistent performance measures and the comparison of resident abuse data across all centers, the department should ensure that each of its centers consistently uses the same data fields within IRIS. During our audit we informed the department that its centers were not always using all of the available data fields within IRIS. Subsequently, the department issued a memorandum to all of the executive directors and OPS commanders at each center directing them to use OPS data fields to track report numbers, special investigations, and case outcomes.

Recommendations

As soon as possible, the department should hire a permanent OPS director and permanent OPS commanders that are highly qualified staff capable of performing the administrative functions these positions require.

To help ensure the quality of OPS investigations, the department should revise its OPS training policy to require its law enforcement personnel to attend annually specialized trainings that address their specific needs. At least initially, the department should focus the additional trainings on communicating with residents, writing effective investigative reports, and collecting investigative evidence. To further develop the leadership skills of OPS management, the department should consider having experienced or particularly skilled members of its OPS management provide this annual training.

To ensure that it has adequate numbers of staff to properly and promptly investigate developmental center incidents, the department should address the high number of vacancies within OPS by instituting a formal recruitment program in accordance with the guidance provided in the California State Personnel Board's *Merit Selection Manual*, as well as using input from OPS law enforcement personnel.

After the department has implemented a formal OPS recruiting program, if it can demonstrate that it is still having trouble filling vacant OPS positions, the department should evaluate how it can reduce some of the compensation disparity between OPS and the local law enforcement agencies with which it competes for qualified personnel.

To make certain that residents receive an adequate level of care and are protected from harm, the department should encourage Human Resources—which is responsible for negotiating labor agreements with employee bargaining units—to include provisions in future collective agreements to cap the number of voluntary overtime hours an employee can work and/or require departments to distribute overtime hours more evenly among staff. If, in the next round of negotiating bargaining unit agreements, Human Resources does not include provisions to cap the number of voluntary overtime hours an employee can work, the department should continue to advocate for these changes for future agreements. In the meantime, the department should adjust its overtime scheduling and monitoring practices to strengthen, where possible, procedures designed to ensure that staff working overtime do not compromise residents' health and safety.

To minimize the need for overtime, the department should reassess its minimum staffing requirements, hire a sufficient number of employees to cover these requirements, and examine its employee scheduling processes.

To ensure that staff who work overtime are paid the correct amount, developmental center management should require all staff to submit not only overtime approvals, but also the department's standardized form showing time off and overtime hours. Additionally, the department should establish a written guide to help ensure that timekeeping staff follow the overtime provisions of the various laws, regulations, and bargaining unit agreements.

The department should create specific measurable goals for OPS that include existing and new measures associated with each one, such as staffing, overtime, and the timely completion of investigations. In addition, the department should perform a regular review of the quality of OPS's activities and investigations to achieve those goals. The department should track progress in quality measures over time and adjust its training plans to increase OPS law enforcement personnel's skill and compliance with established policies and procedures.

To allow for the creation of consistent performance measures and comparisons of resident abuse data across all developmental centers, the department should ensure that each of its centers consistently uses the same data fields in IRIS.

Chapter 3

THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH HAS STRUGGLED TO COMPLETE ALL OF ITS REQUIRED OVERSIGHT OF DEVELOPMENTAL CENTERS

Chapter Summary

The California Department of Public Health (Public Health), the agency responsible for inspecting health care facilities in California, performed some of its oversight activities for the developmental centers in compliance with state and federal laws and regulations as well as with established policies and procedures. For example, it generally performed its certification surveys on time. Even so, Public Health has struggled to perform all of its licensing surveys and conduct all certification survey revisits in a timely manner. Further, it has been delayed in investigating some alleged or potential violations, thus missing opportunities to prevent the potential escalation of problems within centers. Finally, because Public Health has not prepared a required report, the effectiveness of its enforcement practices, particularly those related to developmental centers, remains uncertain.

While Public Health Generally Performed Certification Surveys as Required, It Frequently Failed to Perform Licensing Surveys

Although Public Health appears to be conducting most of the federal certification surveys on time for the five developmental centers, it failed to perform all state licensing surveys on time or at all. As described in the Introduction, Public Health is required to perform periodic on-site inspections, called surveys, for both state licensing and federal certification. The licensing surveys relate to state requirements for operating health facilities. The federal Centers for Medicare & Medicaid Services (CMS) requires states to survey health care facilities, such as the ones at the developmental centers, in order to certify as eligible to receive federal funding. These federal certification surveys evaluate the quality of care provided and verify whether a provider meets applicable federal conditions for participation in the Medicare and Medicaid programs. Depending on the services the facility provides, the developmental centers may be licensed and certified as more than one type of health facility, including intermediate care facilities for the developmentally disabled (intermediate care facilities), skilled nursing facilities, and general acute care hospitals. The required frequency for conducting licensing and certification surveys depends on the type of health facility.

We reviewed licensing and certification surveys for fiscal years 2005–06 through 2011–12 to assess Public Health's compliance with the required survey schedules. Of the 60 federal certification surveys it needed to perform, Public Health conducted 58 surveys on time and was late on two by roughly six months. In contrast, as shown in Table 10, Public Health did not perform 29 of 50 required state licensing surveys. Further, of the 21 licensing surveys Public Health did complete, one was performed late. In a particularly egregious example, we found that, despite issuing 45 citations or monetary penalties to the Sonoma Developmental Center's (Sonoma) skilled nursing and intermediate care facilities between fiscal years 2006–07 and 2011–12 as a result of complaint or incident investigations, Public Health failed to conduct any of the nine required licensing surveys during this time.

Table 10
State Licensing and Federal Certification Surveys Conducted by the California Department of Public Health at the Five Developmental Centers
Fiscal Years 2005–06 Through 2011–12

	FEDERAL CERTIFICATION SURVEYS			
FACILITY TYPE (REQUIRED TIME FRAME)	ON TIME	LATE	NOT COMPLETED	TOTAL REQUIRED
Intermediate care facilities for the developmentally disabled (every 15.9 months)	29	0	0	29
Skilled nursing facilities (every 15.9 months)	23	0	0	23
General acute care hospitals (every three years)	6	2	0	8
Totals	**58**	**2**	**0**	**60**

	STATE LICENSING SURVEYS*			
FACILITY TYPE (REQUIRED TIME FRAME)	ON TIME	LATE	NOT COMPLETED	TOTAL REQUIRED
Intermediate care facilities for the developmentally disabled (every two years)†	13	0	13	26
Skilled nursing facilities (every two years)†	7	1	8	16
General acute care hospitals (every three years)	0	0	8	8
Totals	**20**	**1**	**29**	**50**

Source: California State Auditor's analysis of reports of licensing and certification surveys provided by the California Department of Public Health (Public Health) from the federal Automated Survey Processing Environment (ASPEN) database.

Notes: We determined that a survey never occurred if the survey did not appear in the complete report of licensing and certification surveys for July 1, 2005, to June 30, 2012.

Also, as stated in Table 2, beginning on page 17, we determined that the survey data in ASPEN are of undetermined reliability. However, we present these data in the report because they represent the best source available.

* A state law affecting the licensing survey requirements for certain types of facilities became operative on July 1, 2007. For these types of facilities, including intermediate care facilities for the developmentally disabled and skilled nursing facilities, we examined licensing surveys and violation or citation data starting in July 1, 2006, and going through June 30, 2012. Also, we excluded one licensing survey conducted after the survey requirement was already satisfied in a given year.

† According to state law, for certain types of facilities, Public Health must conduct inspections annually if they have had "AA", "A", or "B" violations in the past 12 months. Facilities without violations in the past 12 months must be inspected at least once every two years.

When asked about the missing or late licensing surveys, the chief of field operations overseeing Public Health's Licensing and Certification (operations chief) cited workload prioritization and staffing limitations. He explained that a change in law dramatically increased the number of surveys that Public Health is required to conduct. Beginning in 2007, state law required Public Health to conduct licensing surveys of long-term health care facilities, which includes skilled nursing facilities and intermediate care facilities, already certified to participate in Medicare and/or Medicaid—facilities that previously had been exempt from these surveys. Under this law, the Legislature intended Public Health to inspect long-term health care facilities using state standards to the extent that they are stricter or more precise than federal standards.

State law explicitly intends for licensing inspections to be conducted in conjunction with federal certification surveys when possible.

Although the law explicitly intends for the State's licensing inspections to be conducted with the federal certification surveys when possible, the operations chief cited staffing limitations as an obstacle to performing these surveys simultaneously. He explained that Public Health may not always have the additional staff to add to a survey team to conduct a simultaneous licensing survey. Although we appreciate the challenges that this law may present, it also expressly asserts that the State's inability to conduct a single survey does not exempt it from inspecting long-term health facilities for state-based requirements. Further, when enacted, the law permitted Public Health to increase licensing fees to recover any additional costs incurred by these changes. Therefore, we believe that Public Health should explore ways to overcome its staffing obstacles, as well as explore opportunities to increase survey efficiency.

Public Health cited several other reasons for not performing licensing surveys in a timely manner. According to the operations chief, licensing surveys play a limited role in ensuring the quality of care. The operations chief asserted that the licensing surveys tend to place a greater emphasis on nonmedical practices, while federal laws and regulations, which provide details for conducting certification surveys and investigations, are generally focused on assessing quality of care and clinical standards.

Despite the operations chief's statement that licensing surveys play a limited role in ensuring quality of care, we noted that Public Health cited developmental centers for some deficiencies related to patient safety and quality of care during the licensing surveys it did conduct. For example, Public Health cited two facilities for deficiencies in protecting patient rights, one facility for deficiencies in its infection control policies and procedures, and another facility for services not meeting professional standards of quality during licensing surveys between fiscal years 2008–09 and 2011–12. Finding deficiencies such as these during licensing surveys suggests that the state surveys provide some level of assurance regarding

Public Health's failure to conduct licensing surveys as required by state law may make the licensing of facilities less meaningful and may provide less assurance to residents.

the quality of care and protection of residents. If Public Health questions the role of licensing surveys in ensuring the quality of care, we believe that it should recommend changes to the law to revise inspection requirements. Otherwise, Public Health's failure to conduct licensing surveys as required by state law may make the licensing of facilities less meaningful and may provide less assurance to residents.

Public Health's Follow-Up on Certification Surveys Was Not Timely in Some Instances

Public Health has at times been late in performing revisits and desk reviews that are to follow certification surveys, thus prolonging the period that facilities at developmental centers can operate under noncompliant conditions. When conducting surveys, Public Health surveyors document any deficiencies in conditions as required by state or federal regulations for health facilities. Depending on the severity of the deficiencies found during a certification survey, Public Health may need to revisit the facility to verify that it has corrected the deficiency and certify that the facility is now in compliance. In these cases, as stated by CMS guidance, Public Health must conduct the first revisit within 45 calendar days of the certification survey. If a second revisit is required, Public Health must conduct it within 46 to 90 days of the certification survey.

If the deficiencies are less severe, Public Health does not have to conduct an on-site revisit but instead can perform a desk review to verify compliance. However, even for these less severe deficiencies, federal guidance generally requires facilities to provide an acceptable plan of correction for resolving deficiencies within 60 days.[9] While Public Health has not established desk-review policies, including how quickly these reviews must be performed, Public Health cannot determine whether a facility has an "acceptable" plan to resolve deficiencies within 60 days, in accordance with federal guidance, unless it is actually reviewing that plan at least within 60 days from its original certification survey.

[9] This federal guidance does not apply to skilled nursing facilities. In fact, there does not appear to be equivalent guidance for these types of facilities. However, the skilled nursing facilities that receive federal reimbursement must correct deficiencies within 90 days or risk denial of payment for any new admissions. Consequently, for Public Health to take appropriate action in response to this 90-day requirement, it must perform its desk reviews within some reasonable time period. Because CMS established 60 days as a reasonable time frame for other facilities with similar levels of noncompliance, we applied the same benchmark to our review of skilled nursing facilities.

We reviewed Public Health's records of certification surveys and the resulting revisits for the developmental centers from fiscal years 2005–06 through 2011–12.[10] Of the 68 first revisits to developmental centers in Public Health's data (regardless of whether they were desk reviews or on-site visits), Public Health completed 43 within 45 days, thus satisfying the requirement for on-site revisits as well as the general time frame for desk reviews. For the remaining 25, we determined that five of them required an on-site visit, and were late, and 20 were desk reviews. As we stated earlier, we believe 60 days is a reasonable time frame for these desk reviews. We found that seven of the 20 desk reviews were beyond this 60-day time frame. Consequently, Public Health appears to have conducted timely follow-ups in 56 of the 68 instances we tested (82 percent). We note that seven of the 12 instances where Public Health's follow-up was not timely relate to Sonoma. As discussed in the Introduction, Public Health decertified certain facilities within Sonoma after finding significant deficiencies in the summer and winter of 2012.

According to federal guidance contained in CMS's *State Operations Manual*, any health care facility that does not substantially meet applicable federal regulations is considered to be limited in its capacity to furnish health care services at an adequate level of quality. Consequently, delays by Public Health in performing desk reviews or on-site visits prolong the time that facilities are allowed to operate while concerns regarding their quality of care persist.

Delays by Public Health in performing desk reviews or on-site visits prolong the time that facilities are allowed to operate while concerns regarding their quality of care persist.

When asked about the timeliness of on-site certification revisits, the operations chief cited various factors that might cause delays in these visits. He explained that revisits cannot be performed until the facility has developed an acceptable plan of correction. Surveys citing numerous significant deficiencies, such as those found at Sonoma, can require extensive plans of correction and multiple revisions, thereby delaying Public Health's acceptance of the plan and the resulting revisit. Therefore, he stated that delays in revisits following surveys with significant findings would be logical. Further, in the cases of desk reviews, the operations chief stated that the surveys for the developmental centers result in large documents relating to hundreds of clients and that the reasonable period of time to achieve compliance may be longer than 60 days at these larger state facilities. Moreover, he stated that the federal regulations are flexible and do allow for an unspecified longer period of time as determined on a case by case basis. Despite these factors that may delay revisits, Public Health must maintain accountability for the timeliness of all of its revisits. Therefore, Public Health should

[10] Federal certification surveys have two portions—a health portion and a life safety code portion. We reviewed the revisits resulting from the health portion of these surveys.

comply with CMS's 45-day on-site revisit requirement. In cases where this time frame is not possible due to delays in accepting a facility's plan of correction, Public Health should seek an exemption from this requirement from CMS. Additionally, Public Health should complete its desk reviews within 60 days.

Public Health Promptly Investigated Incidents Classified as Most Serious but Did Not Consistently Initiate Timely Investigations for Incidents Classified as Less Serious

Although Public Health initiated investigations within the required time frame for developmental center incidents classified as most serious, it did not consistently initiate on-time investigations for incidents considered a lower priority. As part of its oversight role of the developmental centers, Public Health investigates complaints and reported incidents at the centers. Residents, relatives of residents, and concerned individuals may report complaints to Public Health through a variety of channels, including its Web site or by phone. In addition, centers must self-report incidents[11] to Public Health, or they risk fines for failing to do so. After receiving a complaint or reported incident (often referred to as an event), Public Health follows federal guidelines to categorize the event in a range from "immediate jeopardy" at one end to "no action necessary" at the other. These categories are designated by the letters A through H, with "A" indicating immediate action is required and "H" indicating no action is needed.

For some types of events, federal guidelines, as well as state regulations and policies, dictate the time frame within which Public Health must initiate an on-site inspection or investigation.

For some types of events, federal guidelines, as well as state regulations and policies, dictate the time frame within which Public Health must initiate an on-site inspection or investigation. For example, if Public Health prioritizes an event as level A for immediate jeopardy—a situation in which noncompliance has caused or will likely cause serious injury or death to a resident—it must start its investigation within 24 hours. On the other hand, if Public Health prioritizes an event as level E for administrative review/off-site investigation, it does not initiate an on-site investigation and instead performs an off-site review to determine whether further action is necessary. Events receiving priority designations A through D require on-site investigations, while levels E through H do not. In situations where federal and state investigation time frames differ, the operations chief stated that Public Health follows the stricter time frame.

As shown in Table 11, Public Health designates the majority of developmental center complaints and incidents as priority levels C through H. Almost half of all complaints and self-reported incidents—5,825 of 10,737—were assigned level H, meaning no action

[11] These self-reported incidents may also be called entity reported incidents or ERIs.

was necessary. In fiscal year 2011–12, Public Health significantly increased the number of events that it classified as level A or B from the previous three fiscal years we reviewed. The branch chief of one of the regions for Licensing and Certification explained that, while prioritizing complaints and self-reported incidents is a CMS performance standard that it strives to meet, CMS has noted that Public Health has not always met this standard. As a corrective measure, Public Health has established training classes to improve its compliance with this standard. He stated that this training could be one of the reasons why more events are being categorized as levels A and B. Further, he explained that there are many variables, including staff discretion, when inputting complaints and self-reported incidents and that, as a department, Public Health tries to standardize this process.

Table 11
Developmental Center Complaints and Incidents Reported to the California Department of Public Health by Priority Level Fiscal Years 2008–09 Through 2011–12

PRIORITY LEVEL	COMPLAINT AND INCIDENT CLASSIFICATION	FISCAL YEARS				TOTALS BY PRIORITY LEVEL
		2008–09	2009–10	2010–11	2011–12	
A	Immediate jeopardy	–	–	–	5	5
B	High priority	1	–	2	21	24
C	Medium priority	1,101	1,038	739	376	3,254
D	Low priority	381	297	398	524	1,600
E	Administrative review/off-site investigation	–	–	–	27	27
F	Immediate referral*	–	–	1	1	2
G	Other referral*	–	–	–	–	0
H	No action necessary	1,412	1,430	1,615	1,368	5,825
Totals		**2,895**	**2,765**	**2,755**	**2,322**	**10,737**

Source: California State Auditor's analysis of complaint and self-reported incident data provided by the California Department of Public Health from the federal Automated Survey Processing Environment (ASPEN) database.

Notes: We excluded from our analysis the nine complaints or self-reported incidents assigned combination priority levels.

Also, as stated in Table 2, beginning on page 17, we determined that the complaint and self-reported incident data in ASPEN are not sufficiently reliable due to a significant number of limitations we found with this data. However, we present these data in the report because they represent the best source available.

* Referrals are reports to other agencies or boards.

Using data provided by Public Health related to complaints and reported incidents from fiscal years 2008–09 through 2011–12, we analyzed whether it initiated investigations within the appropriate time frames as defined by its own procedures, state law, and federal regulations. However, we were not able to analyze all of the events within this time frame because we found data limitations that hindered our ability to analyze specific events. Of the 10,737 events recorded during this time period, we excluded 859 from our analysis because we found that some events were missing dates and for others the recorded dates indicating when the investigations were initiated occurred before the complaint or incident was reported.

Public Health explained that it follows the rules of the federal database, which requires linking certain events together. However, this can lead to seemingly illogical data. While Public Health provided additional documentation we requested for four events to facilitate our analysis, we could not easily gather the documents needed to find missing dates, evaluate illogical data, or rule out data entry errors for the 859 records we excluded. Consequently, we did not include these specific events in our analysis. Of the events with complete and logical records, we focused on the higher priority levels because these types of events are the most serious in terms of risk to residents' health and safety.

In handling the highest-priority complaints and self-reported incidents, Public Health initiated investigations as required. Specifically, for all five immediate-jeopardy events recorded during this time period, Public Health initiated an investigation within one day. Of the 24 high-priority events we reviewed—with 23 reported by the developmental centers themselves—Public Health initiated investigations within the required 10 working days in 21 instances. Public Health conducted the three remaining investigations between 17 and 201 working days after the event was reported. These delays occurred despite the fact that this priority level includes serious allegations, such as failure to provide appropriate care or medical services, physical abuse or intimidation of a resident, and inappropriate use of restraints resulting in injury.

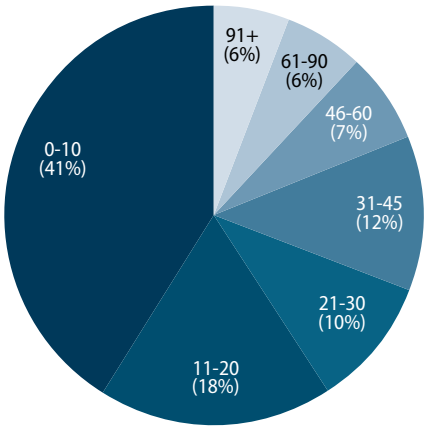
The vast majority of level C medium-priority events are self-reported by the developmental centers—3,212 of the 3,254 medium-priority events. However, there is no designated time frame for initiating investigations for self-reported incidents at this priority level. In contrast, state law established time frames for initiating investigations based on complaints that Public Health receives from residents or concerned individuals. Of the 39 complaints we analyzed that Public Health received and designated as a level C medium priority, Public Health initiated 29 investigations within 10 working days as required (74 percent compliance). Of the remaining 10, four investigations still had not been initiated after 20 working days, twice the number of days required by law. We excluded from our analysis three level C complaints that had investigation initiation dates occurring before the complaint or incident was reported.

If a facility reports an event classified as medium priority, Public Health must schedule an on-site investigation, but there is no required time frame of when the investigation should begin.

Despite the absence of a required time frame for initiating investigations for certain self-reported incidents, we believe that some of the delays we observed are unreasonable. Specifically, we examined the number of days it took Public Health to initiate an investigation after receiving a self-reported incident deemed a medium priority. If a facility reports an event classified as medium priority, Public Health must schedule an on-site investigation, but

there is no required time frame of when the investigation should begin. Because there is no established time frame, it is not surprising that we found significant variation in the time Public Health took to initiate investigations of self-reported incidents. As shown in Figure 7, Public Health initiated investigations within 10 working days for 41 percent of self-reported incidents. However, more than 30 percent of these investigations were not started until more than 30 working days after the incident was reported. Although we recognize that there are no defined criteria establishing the appropriate time frame for beginning the investigations of self-reported incidents, some of the delays shown in Figure 7 appear excessive when compared to the 10-working-day requirement applicable for complaints at the same priority level. To avoid unreasonable delays, Public Health should develop and implement target investigation time frames for priority levels that lack them.

Figure 7
Number of Working Days Between Developmental Centers Reporting Incidents and California Department of Public Health Initiating Investigations of These Incidents It Categorized as Medium-Priority Fiscal Years 2008–09 Through 2011–12



Source: California State Auditor's analysis of reports of developmental centers' reported incidents and investigations provided by the California Department of Public Health from the federal Automated Survey Processing Environment (ASPEN) database.

Note: As stated in Table 2, beginning on page 17, we determined that the incident data in ASPEN are not sufficiently reliable due to a significant number of limitations we found with this data. However, we present these data in the report because they represent the best source available.

When asked about the delayed investigations occurring at various priority levels, the operations chief acknowledged that Public Health could make improvements. For example, when asked about the three high-priority events with delayed investigations, he recognized that Public Health is not meeting this target all of the time, although it is Public Health's policy to meet this goal.

Similarly, when asked about the medium-priority complaints we identified that were not investigated within the required 10 working days, the operations chief acknowledged that this figure leaves room for improvement and stated that Public Health's goal is to initiate 100 percent of complaints at long-term care facilities within 10 days. He noted that the results from this audit provide Public Health an opportunity to stress this point to staff and meet the statutory requirement. Finally, regarding the investigations of self-reported medium-priority incidents, the operations chief noted that CMS has not established guidance specifying a time frame within which surveying agencies, such as Public Health, must initiate these investigations. Similarly, he noted that Public Health has not established its own time frame either, but tries to minimize the length of time that elapses before investigations are initiated while managing the rest of its workload.

Federal guidance within the *State Operations Manual* asserts that prevention is one of the primary objectives of the complaint and incident management system. As such, the manual indicates that complaints that do not allege a threat of serious harm must be investigated to determine whether a problem exists that could have a negative impact on the health care services provided. The manual further states that the investigation of these events is designed to identify and correct less serious issues to prevent them from becoming more serious problems that would threaten the health and safety of the individuals receiving the service. Although we appreciate the challenges inherent in managing Public Health's workload, by delaying its investigations of less serious complaints or incidents, such as the self-reported medium-priority incidents, Public Health appears to be missing opportunities to prevent the potential escalation of problems within the developmental centers.

Public Health is missing opportunities to prevent the potential escalation of problems within the developmental centers by delaying its investigations of less serious complaints or self-reported incidents.

The Effectiveness of Public Health's Enforcement Activities Is Unknown, and Opportunities for Improvement Have Been Missed

Despite a requirement in state law, Public Health has never prepared annual reports specifically addressing the effectiveness of its enforcement system in maintaining the quality of care provided by long-term health care facilities. State law mandates that Public Health review the effectiveness of its enforcement system in maintaining the quality of care by these facilities and submit an annual report to the Legislature on enforcement activities. In addition, Public Health must include any recommendations for additional legislation to improve the effectiveness of the enforcement system or enhance the quality of care within these facilities.

When we asked the operations chief about this required report, he stated that the leadership within Public Health is in the process of discussing this requirement. He acknowledged that although some information about enforcement activities, such as the monetary penalties issued, is included in the annual report Public Health publishes regarding licensing fees, this existing report is not about enforcement effectiveness. Further, the operations chief noted limitations in the enforcement remedies currently available for developmental centers, which suggests that Public Health should make recommendations to the Legislature to address these limitations. With its failure to evaluate or increase the effectiveness of its enforcement system by producing this annual report or making legislative recommendations, Public Health has missed opportunities to improve the system as well as enhance the quality of care.

Because effective enforcement is an integral part of overall effective oversight, we believe that Public Health should begin preparing annual reports analyzing the effectiveness of its enforcement. According to CMS guidance, adequate performance by state survey agencies, like Public Health, includes using enforcement actions to ensure continued compliance. Moreover, a recent report by Public Health identified increasing enforcement effectiveness as an area of improvement for the department. Specifically, in a January 2013 report to the Senate Budget Subcommittee on Health & Human Services, Public Health identified improving enforcement as a particular area of focus. Public Health stated that it will increase compliance through state-issued citations to ensure patient safety. Thus, Public Health must examine the efficacy of its current enforcement actions, such as these citations, to improve its overall oversight and provide greater consumer protection and quality assurance.

Recommendations

To conduct licensing surveys at required intervals while minimizing additional workload, Public Health should explore further opportunities to coordinate the licensing and certification surveys. If Public Health questions the value of these surveys, it should seek legislation to modify the surveying requirements.

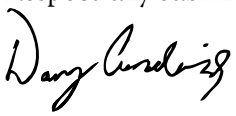
To ensure that the facilities Public Health monitors take timely corrective action on deficiencies, Public Health should comply with CMS's 45-day revisit requirement. If the 45-day revisit time frame is not possible due to the extent of the corrections required at particular facilities, Public Health should seek exemptions from CMS as appropriate. For facilities whose deficiencies are not severe enough to require an on-site revisit, Public Health should direct its staff to complete desk reviews within 60 days.

To ensure that investigations are conducted on a timely basis across priority levels, Public Health should develop and implement target time frames for the priority levels that lack them. Public Health should ensure that the timelines are being met and, if not, explore new ways to increase efficiency and manage its workload, thereby facilitating timely investigations.

To improve its enforcement, each year Public Health should evaluate the effectiveness of its enforcement system across all types of health facilities, including those in developmental centers, prepare the required annual report, and, if called for, recommend legislation to improve the enforcement system and enhance the quality of care.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



DOUG CORDINER, CGFM
Chief Deputy State Auditor

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Appendix A

STATUS OF THE IMPLEMENTATION OF RECOMMENDATIONS FROM THE 2002 REPORT BY THE OFFICE OF THE ATTORNEY GENERAL

In 2002 the Office of the Attorney General (attorney general) commissioned a review of the Law Enforcement Division of the California Department of Developmental Services (department). This division is now called the Office of Protective Services (OPS). This 2002 report by the attorney general, titled *Policing in the Department of Developmental Services: A Review of the Organization and Operations,* provided a total of 28 recommendations to the department related to topics such as law enforcement personnel, performance, organizational structure, and operational procedures. The Joint Legislative Audit Committee directed the California State Auditor to determine the extent to which the recommendations from the attorney general's report were implemented by the department. We obtained the response the department sent to the Senate Office of Research on the status of the recommendations from the report, as well as additional information from OPS on the actions taken to implement these recommendations. Our analysis found that OPS has not fully addressed all of the recommendations.

In June and July of 2012, the department sent three different reports on the implementation of the attorney general's 2002 report recommendations in response to a request from the Senate Office of Research. The department claimed that, of the 28 recommendations, 20 have been completed, seven are ongoing, and one will not be adopted. As shown in Table A on the following pages, our analysis concluded that only 13 of the recommendations have been implemented, that the department has made significant progress in implementing eight recommendations, that it has made some progress for four recommendations, and that it has not addressed one recommendation. Finally, the department fundamentally disagrees with two other recommendations.

One of the recommendations the department disagrees with and will not implement was to allow OPS law enforcement personnel to carry firearms on duty. The department stated that the primary mission of the developmental centers is to provide habilitation and treatment services to residents with developmental disabilities, and that carrying firearms into these residential settings with individuals who could lack impulse control or the ability to make good decisions poses an unacceptable risk. As noted in Table A, several of the recommendations in the attorney general's 2002 report that have not been fully implemented are discussed as continued problems throughout this report. These continued problems include outdated OPS policies and procedures, insufficient OPS recruitment efforts, absence of measurable performance goals for OPS, and the need for bifurcation of administrative and criminal investigations. By not fully addressing these issues in the 11 years since the attorney general's 2002 report, the department has missed opportunities to improve the management of OPS and enhance the protection it provides to developmental center residents.

Table A
Analysis of the California Department of Developmental Services' Implementation of the Office of the Attorney General's 2002 Report Recommendations

	RECOMMENDATIONS FROM OFFICE OF THE ATTORNEY GENERAL'S (attorney general) 2002 REPORT*	STATUS OF RECOMMENDATION IMPLEMENTATION	
1	The Law Enforcement Division should pursue all available means to attract and recruit the highest qualified employees and to retain its trained incumbent personnel.	Since the release of the 2002 attorney general's report, the California Department of Developmental Services (department) has increased the number of its law enforcement personnel. However, as discussed in Chapter 2, the department has not instituted a formal recruitment program for its Office of Protective Services (OPS), and any informal recruitment activities have been negligible in recent years. Also, OPS salaries continue to lag behind local law enforcement agencies in the vicinity of the developmental centers, and the department has not been able to successfully address this issue.	▢
2	The Law Enforcement Division should prepare a mission statement and define both short- and long-term goals.	OPS's mission statement is only included in the duty statement for the commander position and a recent management memo. The mission statement does not appear to be well circulated and is not accompanied by short- and long-term goals.	▢
3	The Law Enforcement Division should complete a policy and procedure manual.	Since 2002 the department has added a number of OPS policies and procedures, and the collection of these documents could be termed a "policy manual." The department recognized the need to improve OPS policies and procedures and hired law enforcement consultants to review OPS policies and help the department finalize an OPS policy manual.	◇
4	A system to measure performance, which provides timely and usable information in direct support of the organizational goals should be developed and implemented.	As discussed in Chapter 2, the department has developed performance measures for OPS and implemented certain reporting requirements to evaluate critical OPS functions. However, the department has not established organizational goals for OPS to compare these measures against.	▢
5	The number of senior special investigators assigned to the developmental centers should be increased, their role and responsibilities should be expanded, and the current openings should be filled.†	Although there has been a noted increase in the number of investigator positions since 2002, only half of those positions are filled. However, in 2012, the developmental center population was less than half of what it was in 2002.	◇
6	The department should create an executive management position that is vested with the responsibility and authority to manage the law enforcement division, and then recruit and hire a highly qualified and experienced law enforcement candidate as that executive.	The department created an executive management position to oversee OPS and initially filled the position with an acting chief with prior experience with the California Highway Patrol. However, we note in Chapter 2 that the department experienced frequent transitions in this and other OPS leadership positions.	◇
7	The Law Enforcement Division should develop and implement a new organization plan.	The new organization, OPS, was created in May 2002, and the current OPS structure is similar to the recommended structure in the attorney general's 2002 report.	✓
8	As part of the reorganization, immediately move to resolve intra-organizational conflicts in the Law Enforcement Division.	The department reorganized the Law Enforcement Division into OPS and created an OPS policy manual. However, as stated in Chapter 1, there is a lack of clarity in a few of the most important OPS policies, such as who is responsible for referring cases to the district attorney.	◇
9	The Law Enforcement Division should develop specific criteria for determining its human resources needs and allocating its personnel.	In its fiscal year 2006–07 budget augmentation for OPS, the department included criteria for determining OPS's human resource needs and allocating OPS personnel.	✓
10	The department should move swiftly and decisively to reorganize and change operational processes within the Law Enforcement Division.	The department created OPS, an executive-level position to oversee OPS, and developed the beginnings of an OPS manual, but has not developed recruiting strategies and organizational goals for OPS.	◇
11	The Law Enforcement Division should institute a training program with relevant specialized courses so its personnel can increase job proficiency.	As discussed in Chapter 2, although OPS has created a training policy that addresses requirements instituted by the Peace Officer Standards and Training Commission, OPS does not require or provide regular trainings that address the specific needs of its law enforcement personal.	◇
12	The role and authority level of the Law Enforcement Division should be explicitly defined to eliminate conflicts and inconsistent practices throughout the department.	The OPS manual better defined the roles and authority of OPS. Even so, we recommend in Chapter 1 that the department clarify who is responsible for making decisions related to specialized medical exams (following a suspected sexual assault) and referrals to district attorneys.	◇

	RECOMMENDATIONS FROM OFFICE OF THE ATTORNEY GENERAL'S (attorney general) 2002 REPORT*	STATUS OF RECOMMENDATION IMPLEMENTATION	
13	The duties and responsibilities of uniformed peace officers should be clearly defined and standardized to maximize individual potential and productivity.	The OPS manual and job duty statements define the duties and responsibilities of OPS law enforcement.	✓
14	The department should standardize the process of reporting incidents to the Law Enforcement Division.	The department has established policies and procedures on the reporting of incidents to OPS.	✓
15	Policies and procedures should be established wherein local law enforcement agencies are immediately notified (as mandated in legislation enacted in 2001) about certain crimes and incidents occurring at the developmental centers.	The department established policies and procedures for notifying local law enforcement agencies of crimes and incidents, as mandated by 2001 legislation.	✓
16	The department should establish a joint agency committee within the jurisdiction of each developmental center to review all department death investigations.	According to the department, activities of this committee would be duplicative and would only hinder the current system of internal and external death reviews.	●
17	The department should develop and use standard criteria to determine which cases are referred to local prosecutors for review.	The department developed policies related to referrals to local prosecutors that describe who will participate in these decisions. However, as we point out in Chapter 1, these policies do not clearly place decision-making responsibility with a particular department official. Further, the policies provide little standard criteria for how these decisions will be made.	◆
18	The Law Enforcement Division should be trained and equipped with the proper supplies and resources to adequately preserve and collect forensic crime scene evidence.	We spoke with OPS commanders at Fairview, Sonoma, and Porterville developmental centers—and each believe that their OPS officers have been provided with crime scene collection and preservation supplies and have been trained on how to use the supplies.	✓
19	Before cases are assigned to special investigators, they should be reviewed and prioritized based upon systemwide standardized criteria.	Although OPS policy states that incidents with possible criminal allegations are first priority, according to the department, it has not created standardized criteria for reviewing and prioritizing cases prior to assigning special investigators.	■
20	The Law Enforcement Division should consider contracting with outside vendors to perform pre-hire background investigations.	The department uses a combination of internal staff at OPS headquarters and outside vendors to conduct pre-hire background investigations.	✓
21	Conflict-of-interest cases should be defined and identified by applying agency-wide criteria, and assigned out for investigation.	The attorney general's 2002 report uses the term "conflict-of-interest cases" to refer to general concerns from client advocates that cases might be subject to bias, manipulation, or cover-up by management at the local level. According to the department, it did not develop a formal policy to specifically address this type of conflict-of-interest case. However, it sought to prevent such circumstances from occurring through a variety of changes, including (1) the police functions were reorganized and commanders no longer report to local management and (2) all incidents involving OPS employees are investigated by department headquarters, another state agency, or a contractor.	✓
22	The current practice of merging criminal and administrative investigations that involve the same circumstances and employees should be modified.	As we discuss in Chapter 1, the department continues to have the same OPS investigator conduct both criminal and administrative investigations.	✗
23	The department should develop and implement a formal field training officer program for all newly hired Law Enforcement Division personnel.	OPS requires new hires to be paired with a field training officer until the officer feels that the new hire is ready to work independently.	✓
24	The Law Enforcement Division radio communication systems should be upgraded, and direct access to local law enforcement's systems should be acquired. The radio dispatcher positions should be Peace Officer Standards and Training (POST) certified public safety dispatchers.	The department believes that this recommendation is not supported by operational needs. Specifically, OPS is not expected to respond to events occurring outside a developmental center, and can immediately report incidents to outside law enforcement as needed with a center's current communication structure. Nevertheless, the department reported making efforts to access radio communications with local law enforcement. However, these efforts, which in part are dependent on local law enforcement agreeing to provide access, were unsuccessful.	✓

continued on next page . . .

	RECOMMENDATIONS FROM OFFICE OF THE ATTORNEY GENERAL'S (attorney general) 2002 REPORT*	STATUS OF RECOMMENDATION IMPLEMENTATION	
25	The methods of accessing the California Law Enforcement Telecommunication Information System (CLETS) should be improved, and additional terminals should be installed in developmental center facilities.	According to the department, CLETS terminals have been installed at the developmental centers at Porterville, Sonoma, and Fairview. The department stated that other developmental centers and facilities, one of which is closing and the other of which is relatively small, do not need terminals.	✓
26	The Law Enforcement Division should have a policy that standardizes safety equipment.	An OPS policy has been established that standardizes and identifies safety equipment.	✓
27	The Law Enforcement Division peace officers should be provided firearms and authorized to carry them while on duty.	The department states that carrying of firearms by OPS law enforcement into residential settings with individuals who could lack impulse control or ability to make good decisions poses an unacceptable risk.	●
28	The Law Enforcement Division should expand and improve all substandard facilities and co-locate uniformed officers and special investigators.	Each OPS branch has its own identified office at which uniformed officers and the special investigators are co-located in satisfactory facilities.	✓

Source: California State Auditor's review of the actions taken by OPS to implement the attorney general's 2002 report recommendations

✓ = Implemented

◆ = Significant Progress

■ = Some Progress

✗ = Not Implemented

● = Department Disagrees

* The attorney general's 2002 report refers to the Law Enforcement Division, which has been reorganized into OPS.

† In November 2010 the Senior Special Investigator position was replaced with the Investigator position.

Appendix B

SPENDING ON OVERTIME PAY BY THE CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES

The Joint Legislative Audit Committee directed the California State Auditor to determine how overtime policies and pay for the California Department of Developmental Services (department) compare to those for other comparable state agencies. We identified three departments within the State that have health care and law enforcement job classifications and responsibilities similar to those within the department. These three comparable departments are the California Department of State Hospitals (State Hospitals), the California Department of Corrections and Rehabilitation (Corrections), and the California Department of Social Services. We obtained the payroll data for the department and these three comparable departments from the California State Controller's Office.

In 2012 the department's employees received nearly $29 million in overtime pay and nearly $281 million in regular pay. As shown in Table B.1, State Hospitals and Corrections had levels of overtime pay similar to the department when expressed as a percent of total earnings.

Table B.1
Overtime Pay and Number of Employees for the California Department of Developmental Services and Comparable Departments in 2012

DEPARTMENT	TOTAL REGULAR PAY	TOTAL OVERTIME PAY	OVERTIME PAY AS A PERCENT OF TOTAL EARNINGS*	AVERAGE NUMBER OF EMPLOYEES PAID REGULAR PAY†	AVERAGE NUMBER OF EMPLOYEES PAID OVERTIME PAY†
California Department of Developmental Services	$280,552,408	$28,588,206	9%	5,226	1,815
California Department of State Hospitals	697,635,975	77,754,533	10	10,653	3,853
California Department of Corrections and Rehabilitation	3,886,637,100	351,211,546	8	54,614	21,442
California Department of Social Services	227,050,065	2,097,506	1	3,902	371

Source: California State Auditor's analysis of payroll data maintained by the California State Controller's Office.

* Total earnings is the sum of regular pay and overtime pay.

† Average number of employees takes into consideration the number of pay periods each employee received a regular or overtime payment during 2012.

We examined individual positions within these agencies and found that the department's Peace Officer I class title had the highest average amounts of overtime as a percent of total earnings when compared to similar job titles. Specifically, the department paid employees in its Peace Officer I class more than $2.8 million in

regular pay and nearly $1.4 million in overtime pay. As shown in Table B.2, the department's Peace Officer II class title was also paid significant amounts of overtime when compared to regular pay.

Table B.2
Comparison of the California Department of Developmental Services' Health Care and Law Enforcement Positions with High Overtime Pay as a Percent of Total Earnings to Similar Positions at Comparable Departments in 2012

DEPARTMENT/CLASS TITLE*	HEALTH CARE POSITIONS	LAW ENFORCEMENT POSITIONS	AVERAGE NUMBER OF EMPLOYEES PAID REGULAR PAY	AVERAGE NUMBER OF EMPLOYEES PAID OVERTIME PAY	TOTAL REGULAR PAY	TOTAL OVERTIME PAY	OVERTIME PAY AS A PERCENT OF TOTAL EARNINGS†
California Department of Developmental Services							
Peace Officer I		✓	58	51	$2,842,790	$1,375,201	33%
Peace Officer II		✓	9	7	504,851	195,962	28
Investigator		✓	16	10	998,339	170,317	15
Psychiatric Technician Assistant	✓		427	309	14,516,786	5,207,053	26
Psychiatric Technician	✓		1,073	667	56,912,409	11,357,824	17
Licensed Vocational Nurse	✓		62	37	2,699,073	524,526	16
Senior Psychiatric Technician	✓		193	130	12,228,837	2,153,359	15
California Department of State Hospitals							
Hospital Police Officer		✓	444	350	23,782,806	8,344,898	26
Hospital Police Sergeant		✓	60	47	3,642,827	759,037	17
Hospital Police Lieutenant		✓	18	11	1,205,251	263,986	18
Investigator		✓	31	10	1,593,580	162,498	9
Psychiatric Technician Assistant (Safety)	✓		289	216	9,765,649	3,985,062	29
Licensed Vocational Nurse (Safety)	✓		146	88	6,617,543	2,171,453	25
Senior Psychiatric Technician (Safety)	✓		293	181	17,528,007	3,918,836	18
Psychiatric Technician (Safety)	✓		2,172	1,238	114,125,755	22,188,362	16
California Department of Corrections and Rehabilitation							
Special Agent		✓	132	34	13,454,513	630,720	4
Licensed Vocational Nurse	✓		1,390	841	66,872,172	11,176,815	14
Registered Nurse	✓		1,628	980	152,900,851	20,851,931	12
Psychiatric Technician (Safety)	✓		535	274	30,907,073	3,714,021	11
Certified Nursing Assistant	✓		160	77	4,170,663	496,979	11

Sources: California State Auditor's analysis of payroll data maintained by the California State Controller's Office and California Department of Human Resources' Civil Service Pay Scales data.

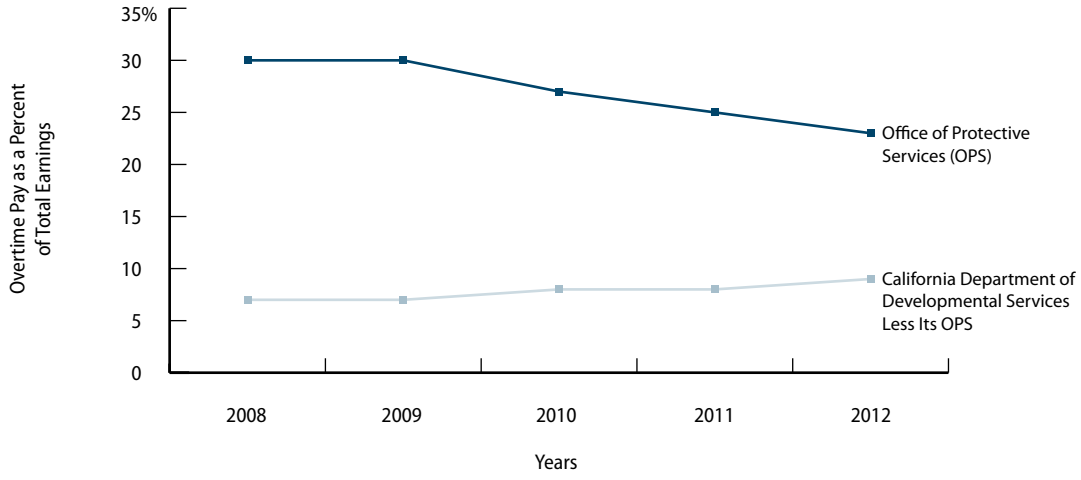
Note: Although we found comparable health care or law enforcement class titles at the California Department of Social Services, none of them were paid overtime during 2012.

* For comparison purposes, we selected the four health care and four law enforcement class titles with the highest amount of overtime pay as a percent of total earnings, excluding class titles that only had a few employees. However, the California Department of Developmental Services (department) had only three law enforcement class titles that were paid overtime in 2012. Also, the California Department of Corrections and Rehabilitation had only one law enforcement class title with overtime in 2012 that has comparable duties to the law enforcement jobs at the department.

† Total earnings is the sum of regular pay and overtime pay.

In April 2009 the deputy director of the Developmental Centers Division issued a memorandum to all OPS commanders requesting that they evaluate overtime within each unit and work to reduce overtime whenever possible. Since this memorandum, OPS has decreased its overtime. However, as illustrated in Figure B, the rest of the department, which consists primarily of its health care staff, slightly increased their use of overtime during the same period. The department's audit coordinator stated that the department's overtime has been affected over the last few years by several factors, including the hiring freeze and furlough program that significantly increased the need for overtime. The audit coordinator also stated that OPS's reduction in overtime was primarily due to the department's aggressive actions to address overtime abuse and other changes, such as the transition away from staffing security towers at the Porterville Developmental Center to employing centralized monitoring through the use of perimeter cameras. Some of the aggressive actions taken by the department include investigations into potential cases of overtime fraud and disciplinary actions for two employees.

Figure B
Overtime Pay as a Percent of Total Earnings* for the Office of Protective Services Compared to All Other Areas of the California Department of Developmental Services
2008 Through 2012



Source: California State Auditor's analysis of payroll data maintained by the California State Controller's Office.

* Total earnings is the sum of regular pay and overtime pay.

Finally, from 2008 through 2012, we analyzed overtime pay as a percent of total earnings for all department staff except those working in OPS at each of the developmental centers we visited. As shown in Table B.3, of the three developmental centers we visited, Sonoma Developmental Center's non-OPS employees had the highest use of overtime as a percent of total earnings for the period of 2009 through 2012.

Table B.3
Overtime Pay as a Percent of Total Earnings by Location for All California Department of Developmental Services Employees Except Those Working in the Office of Protective Services
2008 Through 2012

	OVERTIME PAY AS A PERCENT OF TOTAL EARNINGS				
LOCATION	2008	2009	2010	2011	2012
Department-wide	7%	7%	8%	8%	9%
Porterville Developmental Center	3	3	6	7	7
Fairview Developmental Center	10	7	6	6	8
Sonoma Developmental Center	10	12	12	12	13

Source: California State Auditor's analysis of payroll data maintained by the California State Controller's Office.

Note: Total earnings is the sum of regular pay and overtime pay.

State of California
HEALTH AND HUMAN SERVICES AGENCY

EDMUND G. BROWN JR.
GOVERNOR

DIANA S. DOOLEY
SECRETARY

Aging

Alcohol and Drug Programs

Child Support Services

Community Services and Development

Developmental Services

Emergency Medical Services Authority

Health Care Services

Managed Health Care

Managed Risk Medical Insurance Board

Public Health

Rehabilitation

Social Services

State Hospitals

Statewide Health Planning and Development

June 17, 2013

Elaine M. Howle, State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814
Attn: Tanya Elkins

To Whom It May Concern;

Enclosed you will find a document and compact disk from California Department of Developmental Services and California Department of Public Health in response to Bureau of State Audits draft audit report – Developmental Centers: Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk. If you have any questions or concerns, please feel free to contact me. Thank you.

Sincerely,

(Signed by: Amber Ostrander)

Amber Ostrander
CHHS Audit Coordinator
916-651-8059
aostrand@chhs.ca.gov

STATE OF CALIFORNIA--HEALTH AND HUMAN SERVICES AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF DEVELOPMENTAL SERVICES
1600 NINTH STREET, Room 240, MS 2-13
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1897

June 17, 2013

Mr. Doug Cordiner
Chief Deputy State Auditor
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Mr. Cordiner:

Response to the California State Auditor Draft Audit Report, "*Developmental Centers: Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and [REDACTED] Put Residents at Risk,*" Dated June 11, 2013

Thank you for the opportunity to respond to the draft audit report. Our highest priority is the health and safety of the people we serve. The Department of Developmental Services (DDS or Department) is committed to ensuring that the individuals residing in state-operated developmental centers receive quality care and will continue to work with the California State Auditor (Auditor) to improve services at these facilities.

The Department serves more than 250,000 people with intellectual or developmental disabilities. Over 99 percent of these individuals reside in the community and receive services through 21 regional centers. California currently operates four large developmental centers and one smaller community facility providing licensed health care services to 1,500 residents who have been placed by the courts in these facilities due to their significant medical and/or behavioral needs. Services in the developmental centers are provided by licensed medical staff including doctors, nurses, psychologists and psychiatric technicians. With the emphasis on community integration, the utilization of these facilities has been reduced as more community resources are developed to address the special needs of these individuals.

The Auditor's report on the policies and practices used to protect the residents of developmental centers is consistent with previous reviews conducted by external entities and by the Department. It provides another perspective on further organizational improvements that support the Department's commitment to ensuring that developmental center residents live in a healthy and safe environment. The Department recognizes that despite significant progress to date, more can be done to improve the safety of individuals residing at the facilities.

Mr. Doug Cordiner
June 17, 2013
Page two

As stated in the report, DDS has struggled with recruiting and hiring qualified personnel for the leadership position in the Office of Protective Services (OPS). As an immediate step to improve resident protection at developmental centers, DDS is entering into an interagency agreement with the California Highway Patrol (CHP) for CHP management personnel to serve as the Director of OPS, effective July 2013. The expertise of the CHP will enable DDS to implement the Department initiated reforms already under way and the necessary changes recommended in this report.

In addition, the Auditor's report acknowledged there are multiple levels of oversight that ensure protection of residents from harm. This oversight includes: State and federal licensing and certification reviews and investigations, onsite Clients' Rights Advocates of the State Council on Developmental Disabilities, Disability Rights California (DRC), the DDS internal police force, local external law enforcement agencies, and regional centers.

Nationally and in California, people with developmental disabilities are at greater risk of abuse in our society. Any case of abuse is unacceptable, regardless of where it occurs. Employees of the developmental center are mandatory reporters of suspected abuse or neglect. In 2008, the Department issued a Zero-Tolerance Policy for abuse that provides clear direction in response to allegations of abuse or neglect of developmental center residents. First and foremost, the health and safety of the resident must be immediately addressed. If an employee is implicated by allegation, the employee is immediately removed from resident contact until the case is resolved. If physical abuse is substantiated, the employee is terminated from employment. The policy also requires annual training on mandated reporting requirements and abuse prevention for all developmental center employees.

The developmental centers are licensed by the California Department of Public Health (CDPH), which conducts frequent onsite inspections and responds to facility reported incidents and complaints. Any allegation of abuse, serious injury or unexplained injury, regardless of severity, is reported to the licensing authority to conduct its own independent investigation. It is the Department's policy to err on the side of over reporting to ensure maximum protection of residents, as evidenced by the number of reported incidents in Table 4 of the Auditor's report. Reportable allegations of abuse include physical abuse (by staff or another resident); verbal abuse, including altercations between staff in the presence of residents; and all other types of abuse defined in policy on which all developmental center employees are trained. For example, a small, unexplained bruise is reported to CDPH. In addition, deaths and serious injuries, as required by statute, are reported to external law enforcement and DRC.

Mr. Doug Cordiner
June 17, 2013
Page three

The Auditors indicate that all allegations of abuse are investigated and, as necessary, forwarded to a special investigative unit within OPS or local outside law enforcement agencies. In some cases, they are sent to the District Attorney (DA) for prosecution. Statutes authorize external law enforcement to take the lead on an investigation. The number of investigations and DA referrals in Table 4 do not include cases handled by outside law enforcement which could have been referred to the local DA. Certain incidents, depending on severity, are also reported to DRC, the federally required entity that ensures the rights of individuals with disabilities are not violated.

A new automated incident reporting system has been implemented at all DDS operated facilities. The system improves access to specific incident information at various levels within the Department including first responders, investigators, facility management, and headquarters' staff. This new system was fully implemented at all facilities in November 2012. The Department is still addressing training needs and issues of consistency and data reporting with this new system. The Auditor acknowledges the benefits of this new system.

To further enhance resident protection, in 2012, following significant incidents identified at the Sonoma Developmental Center (Sonoma), the Department requested that DRC conduct an independent review of responses to serious incidents within the developmental centers. Under federal and state law, DRC has the authority to investigate any incident of abuse or neglect of any person with a disability, including residents of developmental centers. DRC medical and consumer rights experts reviewed the Department's response to suspicious or unexpected deaths, sexual assault allegations involving staff and serious injuries of unknown origin in the prior three years at all five state-operated facilities. They identified that reporting laws and policies be strengthened, the incident tracking system be improved, and training enhanced. They also recognized several strengths of OPS investigations. DRC's testimony favorably compared responsiveness and investigations of the DDS internal police force with local law enforcement on similar cases.

As shown in Figure 2 of the Auditor's report, another layer of protection and security for residents within the developmental centers is the Department's sworn law enforcement officers and investigators in OPS. The audit largely focuses on OPS and makes several recommendations for improvement in the areas of training, recruitment, overtime and policy development and implementation, many of which the Department has already implemented.

The OPS includes peace officers and investigators who have all met the regular basic course training requirements and received certification from the State Commission on Peace Officer Standards and Training (POST). Within the intensive POST Basic

Mr. Doug Cordiner
June 17, 2013
Page four

Training program, candidates for employment are required to take over 650 hours of course training, including courses specifically addressing investigative report writing; handling crime scenes; evidence collection and preservation; forensics; investigating sex crimes; and engaging people with disabilities. Every two years after being hired, sworn staff is required to attend 16 hours of Perishable Skills training (skills that POST has determined need a refresher course) and another 8 hours of continuing professional training. In addition, sworn staff receives on-the-job training and training on policies and procedures as updates are issued, as well as training identified by the supervisors and management. This internal law enforcement unit is charged with promptly responding to, and investigating incidents that occur at the facilities. While they function similarly to local law enforcement, members of the Department's police force also require special skills due to the unique needs of the people they protect.

Last year, to address identified training needs, the Department provided "Sexual Assault Forensic Examinations" training for all sworn personnel by a certified Sexual Assault Nurse Examiner. The training included Sexual Assault Response Team (SART) exams, protocol and evidence preservation. A memo was issued in May 2013 to all facility Executive Directors and OPS Commanders clarifying that final determination on when a victim is sent for a forensic medical examination shall be made by OPS, as recommended in this report. Additionally, in May 2013, a comprehensive course on "Conducting Serious Incident Investigations" was provided to OPS investigators representing all developmental centers, including all investigators at Sonoma. The Department supports the Auditor's recommendation to increase specialized training to further professional development of OPS personnel.

High vacancy rates in OPS have led to increased overtime. One of the most significant challenges DDS faces is reducing the reliance on both voluntary and mandatory overtime. As recommended by the Auditor, DDS is strengthening its recruitment efforts to fill vacant positions and reduce overtime utilization. In April 2009, to ensure appropriate use of overtime, the Department issued an OPS directive requiring increased controls over the authorization, verification, documentation, reporting and review of overtime utilization. This and disciplinary actions taken resulted in reduced OPS overtime as shown in the Auditor's report (Appendix B, Figure B). We are continuing to work on reducing our reliance on overtime in OPS and level of care positions, which is most significant at Sonoma.

As reported to the Legislature last year, the Department initiated an extensive review and revision of law enforcement policies to ensure the protection, health and safety of developmental center residents. DDS engaged national law enforcement experts, including two former city police chiefs, to improve the OPS policies and procedures, and to provide training to the Department's law enforcement personnel. Last year, a series

Mr. Doug Cordiner
June 17, 2013
Page five

of policies to improve resident safety were issued and, in June 2012, DDS sworn personnel received three days of training on the requirements for first responder and investigation protocols, reporting and responding to incidents. DDS is working with its consultants to finalize additional policies, which will be issued this month. Throughout this process input was solicited from OPS employees who represented each developmental center and each level of staff within the organization to ensure a collaborative effort in the review of best practices in law enforcement. Recommendations made in the Auditor's report are being incorporated into these revised policies.

The Auditor's report confirms issues already being addressed by the Department. Although statewide and system-wide issues are identified, several of the findings are predominantly associated with the Sonoma Developmental Center, as shown in the charts and narrative, where the Department has taken and continues to take aggressive action. Employees at the facility were terminated or disciplined, including those in leadership positions. After a national search, a new Executive Director was appointed to lead and oversee the needed changes at Sonoma. The CHP was brought in to run the Sonoma Office of Protective Services and implement improved law enforcement practices, some of which are referenced in the Auditor's report. The CHP used their expert trainer to train OPS staff on background investigations, critical incident investigations, drug recognition, and report writing. The CHP is also providing ongoing mentoring and training on interviewing, interrogation and report writing at Sonoma. A corrective action and quality assurance team was deployed at Sonoma consisting of state and national experts to review the entire service delivery system at the facility; and an onsite monitor provided immediate feedback to Sonoma and DDS management. DRC is also doing independent monitoring and unannounced visits at Sonoma and has provided training to managers and supervisors regarding non-criminal investigations at all facilities.

As noted by the Auditor, DDS entered into a Program Improvement Plan (PIP) with the California Department of Public Health (CDPH) and the federal Centers for Medicare and Medicaid Services (CMS) in March 2013, which addresses many of the same investigation, staffing, training and overtime issues raised in this report. The experience at Sonoma is helping to address similar issues statewide. Although there is still work to be done, significant progress has been made to improve the safety of the individuals residing at developmental centers.

Any case of abuse is unacceptable whether it happens in a developmental center or in the community and we will continue to use our best efforts to prevent it from occurring and actively take measures to respond appropriately when it does occur. We will

Mr. Doug Cordiner
June 17, 2013
Page six

continue to report to external oversight and law enforcement entities to ensure all possible incidents of abuse are fully investigated.

The Department appreciates the Auditor's review of the developmental centers and takes seriously the issues raised in the draft report. In response to the audit, DDS has taken immediate steps to implement system improvements and specific changes to address the recommendations. The Department's response to each recommendation is provided below:

Chapter 1

Recommendations:

1. **The department should provide a reminder to staff on the importance of promptly notifying OPS of incidents involving resident safety.**

   Response: DDS agrees with the value of reinforcing the expectation to staff. A written reminder was issued to all developmental center staff on May 29, 2013, requiring prompt incident reporting to OPS. Immediate notification of suspected abuse and neglect is a requirement in each developmental center's policies. The notification requirements to OPS were also incorporated into a revised statewide developmental center policy and distributed to the facilities on May 31, 2013. The prior versions of this statewide policy, distributed in 2004 and 2005, clearly specified the expectation and criteria for incidents to be reported to OPS; however, the recent revision further emphasizes that the notification must be "immediate."

2. **Within 60 days, the department should make the following amendments to its policies and procedures for OPS:**

   - **Clarify who is responsible for deciding whether to make district attorney referrals.**

     Response: DDS agrees with this recommendation. The updated OPS policies (see recommendation 3, below), further clarify that the responsibility for DA referrals rests with OPS based on their determination that there is probable cause that a crime has been committed. The policy calls for a meeting to be held for cases in which a resident is the suspect, prior to referring the case to the DA, however the responsibility for DA referral remains with OPS. The purpose of the meeting is to ensure OPS has all the information needed to inform the decision. Some examples of important considerations include the resident's level of intellectual or developmental

disability, possible challenges to serving the resident in a jail setting, and whether the resident has already been determined by a court to be incompetent to stand trial and, therefore, was admitted to a developmental center.

- **Clarify that the decision to initiate a specialized medical examination for an alleged victim of sexual assault rests with OPS, not health care staff.**

  Response: DDS has implemented this recommendation. The updated OPS policies (see recommendation 3, below), include a policy that clearly specifies that OPS has the final determination on whether to send a potential victim for a forensic medical examination, after consultation with the treating physician.

  Additionally, a memorandum from the Deputy Director of the Developmental Centers Division addressing this clarification was distributed to the Executive Directors of the developmental centers and OPS Commanders on May 31, 2013. The memorandum goes further and includes a process for elevating situations where OPS determines an exam is not needed, but developmental center staff/medical personnel believe one should be conducted, to the OPS Director level for final decision.

- **Require OPS investigators to document their efforts to communicate with alleged victims of abuse, including nonverbal clients, and require supervisors to verify that such efforts have been made when approving investigation reports.**

  Response: DDS agrees with this recommendation. The updated OPS policies (see recommendation 3, below), include a policy that specifies that all OPS investigations must include a summary of attempts made by the investigator to interview the client(s) involved (victim or suspect), including attempts when working with a person who is nonverbal.

- **Direct its investigators to record the potential violations of law or facility policy they identify and considers (*sic*) during each investigation.**

  Response: DDS recognizes the value in this recommendation and will consult with the CHP regarding this component of the investigative best practices.

3. To ensure adequate guidance to OPS personnel, once the department has amended OPS' policies and procedures to reflect the recommendations we have included here, the department and OPS should place a high priority on completing and implementing its planned updates to the OPS policy and procedure manual.

Response: DDS agrees with this recommendation and continues its commitment to this effort. DDS has dedicated significant resources to ensure completion of the updated OPS policies and procedures manual which is to be released in June 2013. It will include 46 policies, including revisions to supersede any existing policies in the current manual. As described below, DDS has used a comprehensive policy development process that involved a high degree of focused reviews and discussion among OPS leadership, OPS personnel and external law enforcement consultants.

Initially, DDS contracted with law enforcement experts, including two former police chiefs, to work with DDS, finalize policies to improve all first responder and investigation protocols, and develop related training. Training was provided in June 2012 for all OPS sworn personnel on these policies.

These law enforcement experts were also engaged to review and revise other existing OPS policies, develop new policies, advise DDS on best practices, and provide guidance on system improvements. The policy and procedures review was coordinated by the law enforcement experts, working with the OPS Interim Chief, to ensure an expedited process of reviewing, revising, and expanding policies in the current OPS policy manual. Throughout this process the consultants solicited input from a diverse team of OPS employees representing each developmental center and each level of staff within the organization, from rank and file to Commanders, to ensure a collaborative effort in the review of best practices in law enforcement.

Subsequently, the draft policy manual was distributed and was collectively reviewed by the Commanders and Lieutenants from the developmental centers during a five day session in mid-May 2013. Comments and proposed edits have been reviewed by the OPS law enforcement experts, a retired CHP Assistant Chief, OPS Commanders and the Interim Chief. A new OPS Policy Manual will be established upon completion of the 46 policies currently in their final stages of review, including the policy on evidence preservation and collection. The updated OPS Policy Manual is to be released by the end of this month.

Additionally the OPS Interim Chief, working with the facility Commanders, will train all OPS personnel on the updated and new policies. Training on these policies and

procedures to OPS sworn personnel is expected to be completed no later than August 1, 2013.

4. **OPS should provide additional training to its peace officers on how to conduct an initial incident investigation, particularly regarding collection of written declarations and photographs of alleged victims following an incident.**

   Response: DDS agrees with this recommendation. The updated OPS policies (see recommendation 3, above), include practices associated with evidence collection including, but not limited to, expectations of first responders, when to take photographs and/or collect staff affidavits, and access to the evidence room. These policies were developed with the guidance of law enforcement experts, including two former California Police Chiefs. As indicated previously, training will occur on the new policies.

   Since the bulk of the problems identified by both DDS and the Auditor were at Sonoma, the CHP expert trainer provided training to OPS at Sonoma. This training, conducted in January and February 2013, as well as the ongoing daily hands-on training and mentoring by the CHP, is already improving the quality of the initial incident investigations.

5. **To avoid jeopardizing the integrity of its criminal investigations with compelled statements acquired through administrative admonishments, the department should require that a different OPS investigator conducts the administrative investigation and the criminal investigation when it involves the same incident.**

   Response: DDS is committed to implementing best practices and will consult with additional external law enforcement experts for input on the appropriate method of addressing this recommendation. Before implementing any change, the issue needs to be thoroughly researched, policies and procedures carefully developed, and organizational impacts addressed. Although separating the administrative and criminal investigations was noted as an “industry” standard in the 2002 Attorney General’s report, throughout the extensive process of seeking input from law enforcement experts for policy development, DDS has received conflicting guidance as to the appropriateness of requiring different investigators for administrative and criminal investigations of the same incident. DDS will continue to evaluate implementation of the recommendation.

Mr. Doug Cordiner
June 17, 2013
Page ten

Chapter 2

Recommendations:

1. **The department should hire a permanent OPS director and permanent OPS commanders as soon as possible for its developmental centers that are highly qualified staff capable of performing the administrative functions these positions require.**

   Response: DDS agrees with this recommendation. The Department initiated an extensive nationwide recruitment effort for the Director of OPS, including notifications sent to all California law enforcement agencies and national law enforcement organizations. Based on a review of the applicant's work history and prior law enforcement experience, several candidates were selected for interview, but only four candidates participated. There were no individuals identified in this process that could assume the responsibility of the position. The Department is entering into a two-year Interagency Agreement for CHP management personnel to serve as the Director of OPS, effective July 2013, and will renew recruitment efforts for the position before the end of the contract period. The expertise of the CHP will enable DDS to implement Department initiated reforms already under way and the necessary changes recommended in this report.

   Currently, Sonoma has an Interagency Agreement in place with the CHP to provide the OPS law enforcement leadership for Sonoma. The Department conducted hiring interviews for the other two vacant Commander positions in the developmental centers. One individual has been tentatively selected and a background review is underway. The Department will continue its efforts to fill leadership positions when vacancies occur.

   To assist with recruiting and selecting well-qualified applicants for these critical positions, the Department recently entered into a contract with Cooperative Personnel Services (CPS). The CPS is uniquely qualified to meet the human resources needs of state departments. With more than 25 years of human resources experience in the public sector, they have established a long record of success with state government agencies across the country.

   The CPS contract scope is to develop and implement an assessment center, similar to what is used by the CHP and the Department of Justice, for the examination process of the Commanders and first-level OPS supervisory positions at the developmental centers. Assessment centers for selection and promotion utilize an objective, job-related approach to assessing an individual's

capability to perform in a supervisory, managerial or leadership role. Candidates complete a battery of testing procedures that assesses job-related expertise and competency. The assessment center will provide an objective and thorough evaluation of the candidates for the OPS supervisory classifications to ensure the most qualified individuals are identified to fill the positions.

2. **To help ensure the quality of OPS investigations, the department should revise its OPS training policy to require its law enforcement personnel to annually attend specialized trainings that address their training needs. At least initially, the department should focus the additional trainings on communicating with residents, writing effective investigative reports, and collecting investigative evidence. To further develop the leadership skills of OPS management, the department should consider having experienced or particularly skilled members of its OPS management provide this annual training.**

   Response: DDS agrees with the intent of this recommendation and supports the need for additional specialized training for its law enforcement officers. The additional training will strengthen OPS law enforcement activities. DDS will first concentrate on the three areas identified by the Auditor. A process will be developed that considers OPS supervisor and manager input as well as progress on measurable goals (see recommendation 8, below) to identify needs and plan for specialized training in the future.

   All Department sworn law enforcement officers and investigators are certified by POST, which provides standard training courses for all California law enforcement personnel on topics such as investigative report writing; handling crime scenes; evidence collection and preservation; forensics; and investigations involving people with disabilities. The intensive POST Basic Training program provides more than 650 hours of courses to candidates prior to their employment as peace officers. Every two years after being hired, sworn staff is required to attend 16 hours of Perishable Skills training (skills that POST has determined need a refresher course) and another 8 hours of continuing professional training. In addition, sworn staff receives on-the-job training and training on policies and procedures as updates are issued, in addition to training as determined by the supervisors and management.

   The Department recognizes the value of both internal and external trainers and will incorporate both into its training program. As stated previously, a number of external trainers have been resourced to improve the quality of OPS investigations. With law enforcement consultants in June 2012, OPS personnel were trained on the policies and procedures for responding to incident reports and conducting investigations.

DDS provided "Sexual Assault Forensic Examinations" training in July 2012 for all sworn personnel by a certified Sexual Assault Nurse Examiner. In January and February 2013, the CHP POST-certified Trainer provided training on "Basic Reporting Writing, Drug Recognition, Background Investigations, and Critical Incident Investigations" to OPS at Sonoma. The CHP continues to provide daily hands-on interview and interrogation training, report writing training, and mentoring to OPS at Sonoma. Additionally, in May 2013, a comprehensive course on "Conducting Serious Incident Investigations" was provided to OPS investigators representing all developmental centers, including all investigators at Sonoma.

3. **To ensure it has adequate numbers of staff to properly and promptly investigate developmental center incidents, the department should address the high number of vacancies within OPS by instituting a formal recruitment program in accordance with the guidance provided in the State Personnel Board's *Merit Selection Manual*, as well as using input from OPS law enforcement personnel.**

Response: DDS agrees with the recommendation to address the high number of vacancies within OPS. The developmental centers have been experiencing difficulty in attracting qualified candidates for the Peace Officer and Investigator positions due to the facility locations, declining resources, and the potential downsizing of jobs due to decreases in developmental center populations. The Department continues its recruitment efforts to fill the Peace Officer and Investigator positions at the developmental centers.

It is important to note that as of June 12, 2013, the OPS vacancy rate has been reduced to 33.5 percent with 11 candidates currently undergoing a background investigation prior to being hired, which will further reduce the vacancies. This is an improvement from the information provided in Table 7 where OPS had a vacancy rate of 42.8 percent at the beginning of the year.

In addition to contracting with CPS for an assessment center as described in the response to Chapter 2, recommendation 1, the Department contracted with CPS to develop and implement a plan for recruitment for the Peace Officer and Investigator classifications. The OPS and Human Resources Section of DDS will work closely with CPS to identify the critical skills, knowledge and abilities for these positions and explore various options for the focused recruitment of well-qualified candidates. The CPS will assist the Department with the initial implementation of the recruitment plan before turning this function over to DDS. The CPS anticipates the formal recruitment plan will be ready by July 31, 2013. Specific activities and time frames for

implementation of the recruitment plan will be established after receipt of the plan from CPS.

To remove an initial barrier for recruitment, the examinations for the Peace Officer I have been changed and are now offered as continuous filing examinations which allow the Department to add a candidate to the existing hiring list as soon as an application is received and the individual exam is scored. For the Investigator classification, DDS participates in the consortium online exam given by the State Personnel Board. This is also a continuous filing exam and names are merged onto existing hiring lists after the applicants are scored. This type of exam supports improved recruitment and hiring.

4. **After the department has implemented a formal OPS recruiting program, if it can demonstrate that it is still having trouble filling vacant OPS positions, the department should evaluate how it can reduce some of the compensation disparity between OPS and local police agencies with which it competes for qualified personnel.**

   Response: DDS agrees that recruitment of OPS classes may be impacted by local compensation disparity, among other factors. As stated in the Auditor's report, the compensation for the OPS classifications is comparable to similar classifications used by the Department of State Hospitals and California Department of Corrections and Rehabilitation. The Department will engage the California Department of Human Resources (CalHR) to explore appropriate remedies if the recruitment plan is not successful in reducing vacancies in OPS.

5. **To make certain that residents receive an adequate level of care and are protected from harm, the department should encourage the Department of Human Resources—which is responsible for negotiating labor agreements with employee bargaining units—to include provisions in future collective agreements to cap the number of voluntary overtime hours an employee can work and/or require departments to distribute overtime hours more evenly among staff. If the Department of Human Resources does not include provisions to cap the number of voluntary overtime hours an employee can work in the next round of bargaining unit agreements, the department should continue to advocate for these changes for future agreements. In the meantime, the department should adjust its overtime scheduling and monitoring practices to strengthen, where possible, procedures designed to ensure that staff working overtime do not compromise the health and safety of residents.**

Mr. Doug Cordiner
June 17, 2013
Page fourteen

Response: DDS is making every effort through recruitment and hiring to fill vacant positions to reduce the developmental centers' reliance on both voluntary and mandatory overtime to provide essential services to residents. As shown in the Auditor's report, the amount of OPS overtime has been reduced since 2009 (see Appendix B, Figure B). We are continuing to work on reducing our reliance on overtime in OPS and level of care positions.

In April 2009, the Department issued a directive to OPS commanders on overtime that resulted in improved management of overtime overall, heightened awareness of procedural requirements for overtime, and regular reporting to the OPS Chief and the Deputy Director for monitoring of overtime use. The Deputy Director of the Developmental Centers Division currently receives monthly overtime reports to review and evaluate the level of overtime at each developmental center.

The memorandum on OPS overtime distributed in April 2009 specified the responsibility of the employee and the supervisor to ensure that each employee who works overtime has the ability to perform the functions of the job and is able to be attentive to the work required while working. This policy memorandum is being incorporated into the updated Policy Manual that is due to be released this month. In addition, the policy will specify that the OPS Commander may deny the assignment of overtime to any employee demonstrating fatigue, such as the inability to stay awake, reduced attention and vigilance, reduced reaction time--both in speed and thought, or failure to respond to changes in surroundings or information provided. Non-OPS supervisors are also responsible for ensuring employees who work overtime are able to perform the functions of the job. As highlighted in the Auditor's report, overtime utilization was a significant issue at Sonoma, where aggressive hiring has been underway for several months that will reduce the reliance on overtime to provide essential services at the facility.

As identified in the Auditor's report, overtime is managed through the individual bargaining unit agreements, and the Department will inform CalHR of the recommendation made by the Auditor. In the interim, DDS is issuing a reminder to all supervisors of their responsibility to assess an employee's readiness and ability to work overtime hours at the beginning of each shift. The Department will also determine if modifications to the overtime scheduling practices can be achieved within existing bargaining unit agreement requirements.

6. To minimize the need for OT, the department should reassess its minimum staffing requirements, hire a sufficient number of employees to cover these requirements, and examine its employee scheduling processes.

Mr. Doug Cordiner
June 17, 2013
Page fifteen

Response: DDS agrees with this recommendation. Minimum staffing requirements are regularly reassessed at all developmental centers, not only to address staffing needs and reduce reliance on overtime, but to assure the staffing sufficiently meets the acuity needs for each residential/program area. The acuity needs in each area may increase or decrease as residents' service and support needs change. As licensed and certified facilities, the developmental centers must regularly review the staffing complement to determine whether there are enough staff to provide the services and supports to the residents in each residential/program area. Overtime is required when the acuity increases call for more staff than staffing standards provide.

The Department will focus its hiring activities in areas where the number of employees is insufficient to avoid significant reliance on overtime. As indicated in Appendix B, non-OPS employees at Sonoma had the highest use of overtime as a percent of total earnings for the period of 2009 through 2012 (Table B.3). DDS is already addressing this issue by reducing vacancies at Sonoma. In the last three months aggressive hiring has resulted in over 65 new employees with an additional 50 candidates going through the extensive background clearance process.

As reported in Appendix B, DDS is not dissimilar in its use of overtime when compared to other state-operated facilities in the Department of State Hospitals and the Department of Corrections and Rehabilitation. Further, Figure B shows the significant decline in the utilization of overtime by OPS personnel due to greater controls implemented in 2009. These controls strengthened the approval, review and oversight of overtime in OPS.

DDS has expanded its oversight of overtime usage to all areas of the developmental centers. The Developmental Centers Division collects monthly reports of overtime usage, and in May 2013 the expectation was memorialized in a system-wide policy on the responsibilities of the Governing Body (directorate and management team). It included a template for the monthly report of overtime, and specified that the reports would be included in the briefing book for the quarterly Governing Body meetings with the Deputy Director.

7. **To ensure that staff who work overtime are paid the correct amount, developmental center management should require all staff to submit not only overtime approvals, but the department's standardized form showing time off and overtime hours. Additionally, the department should establish a written guide to help ensure that timekeeping staff follow the overtime provisions of the various laws, regulations, and bargaining unit agreements.**

Response: DDS agrees with this recommendation. As the Auditor's report stated, the developmental centers are implementing processes, which include training and monitoring, to ensure the accurate reporting of time worked and the processing of payroll. The Deputy Director for the Developmental Centers Division issued instructions on May 14, 2013, to all facilities requiring them to review their procedures and ensure appropriate processes are followed, including the consistent use of the standardized attendance form, in the approval and payment of overtime. The Department's Personnel Officer recently met with developmental center Personnel Officers to assess the training needs related to the standard attendance forms and the various requirements for the approval and payment of overtime. In addition, written guidelines are being developed for utilization by all developmental centers. Training will be developed and provided to timekeeping staff on the requirements for the approval and payment of overtime. Both the guidelines and the training will be completed by the end of September 2013. Additionally, the developmental centers are correcting the four overtime calculation errors identified by the Auditor and recovering the $300 in total overpayments.

8. **The department should create specific measurable goals for OPS that includes (*sic*) existing, and new measures associated with each one, such as staffing, overtime, and the timely completion of investigations, and also a regular review of the quality of OPS' activities and investigations in achieving those goals. The department should track progress in quality measures over time and adjust its training plans to increase OPS law enforcement personnel's skill and compliance with established policies and procedures.**

   Response: DDS agrees with this recommendation. As noted in the report, the Department already tracks and evaluates data associated with staffing, overtime utilization and investigations. The Department will clearly delineate the goals of OPS and the data collected, plus any other identified performance indicators used to measure progress toward achieving those goals.

   As stated in our response to Chapter 2, recommendation 2, DDS will design an annual training program around specialized training needs and key issues. This training will focus on improving OPS staff skills and compliance with policies and procedures, and specifically address areas where measureable goals have been established.

9. **To allow for the creation of consistent performance measures and comparisons of resident abuse data across all developmental centers, the department should ensure that each of its developmental centers consistently uses the same data fields in IRIS.**

Mr. Doug Cordiner
June 17, 2013
Page seventeen

Response: DDS agrees with this recommendation and efforts are already underway. As previously mentioned, this new system was installed at all developmental centers in the latter part of 2012, and the Department is still addressing training needs and issues of consistency and data reporting with this new system.

Throughout the training and implementation phases of IRIS, the DDS project manager for IRIS has developed and maintained a variety of tools to support staff as they navigate the data fields. Retraining was, and continues to be provided to employees individually and collectively, as needed.

The Deputy Director of the Developmental Centers Division issued a memorandum on May 14, 2013, that clarifies parameters for immediate implementation to streamline the process and ensure accuracy and accessibility of the information entered into the IRIS database, including the responsibilities for OPS to document notifications to outside law enforcement and information related to special investigations and findings. DDS will continue to monitor the data entry and usage, and implement any further refinements to the process that are identified.

In closing, DDS is committed to ensuring the health and safety of residents living in developmental centers. The Auditor's report recognizes progress made by the Department to improve systems and policies that ensure resident safety. DDS also supports the Auditor's recommendations to strengthen areas that further increase protections and reduce risk to developmental center residents. Many of these recommendations have already been implemented or are underway. We appreciate the Auditor's review and will continue to work collaboratively with the Auditor to improve developmental center services in California.

Thank you for the opportunity to provide input to the draft report. Please contact me or Mark Hutchinson, Chief Deputy Director, at (916) 654-1897, if you have any questions or concerns.

Sincerely,

Original Signed by Mark Hutchinson for:

TERRI DELGADILLO
Director

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Enclosed is the California Department of Public Health's (CDPH) response to the Bureau of State Audits draft report entitled, "Developmental Centers: Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk," Report 2012-107, July 2013.

Thank you for the opportunity to respond. If you have questions, please contact Jean Iacino, Acting Chief, Internal Audits, at 916-445-0938.

Sincerely,

Kathleen Billingsley for Dr. Ron Chapman

Ron Chapman, MD, MPH
Director & State Health Officer

Enclosure

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* California State Auditor's comments begin on page 99.

California Department of Public Health Response to Draft Report: "Developmental Centers: Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk" Report 2012-107 July 2013

Recommendation 1

To conduct licensing surveys at required intervals while minimizing additional workload, Public Health should explore further opportunities to coordinate the licensing and certification surveys. If Public Health questions the value of these surveys, it should revise the regulations used during these surveys to maximize their value or seek legislation to modify the surveying requirements.*[*]

Response 1

The California Department of Public Health (CDPH) agrees with this recommendation and is in the process of implementing it.

In 2008, CDPH implemented a policy to coordinate federal certification and licensing survey activities as much as possible to most efficiently use staff resources (See Exhibit A,[†] Skilled Nursing Facility (SNF) Licensing Survey Process – first sentence). CDPH continues efforts to maximize efficient use of staff resources.

In addition, during the 2012-13 Spring Budget revision process, the Administration proposed using only the federal certification standards (and eliminating state licensing survey requirements) for long-term care facilities (See Exhibit B,[†] Budget Subcommittee #3 Agenda page 14). This proposal applied to skilled nursing facilities and intermediate care facilities for the developmentally disabled certified for participation in Medicare or Medicaid. The Legislature did not move forward with the proposal, but indicated that the proposal should be considered as a policy recommendation and not through the budget process.

Further, CDPH is contracting for an organizational assessment of the effectiveness and performance of the Licensing and Certification (L&C) program. This assessment will be completed in a two-step scope of work and will be completed by July 31, 2015. The first step will include an assessment of L&C's resources, mandates, performance, management processes, and organizational culture. The second scope of work will assess the findings from the first review and propose opportunities for L&C to implement operational efficiencies and best practices. Depending on the findings in the second assessment, CDPH may recommend proposed legislation to improve efficiencies.

* After the California Department of Public Health responded to our report, we made minor changes to the wording of the recommendation.

† Because of their length, these exhibits are not included in the report. However, they are available for public review at the California State Auditor's Office.

California Department of Public Health Response to Draft Report: "Developmental Centers: Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk" Report 2012-107 July 2013

Recommendation 2

To ensure that the facilities Public Health monitors make timely corrective action of deficiencies, Public Health should comply with CMS's 45-day revisit requirement. If the 45-day revisit time frame is not possible due to the extent of the corrections required at particular facilities, Public Health should seek exemptions from CMS as appropriate. For facilities whose deficiencies are not severe enough to require an onsite revisit, Public should direct its staff to complete desk reviews within 60 days.

Response 2

CDPH agrees with the recommendation. By July 2013, CDPH will implement a tracking log to monitor this performance metric. The log will track all surveys in which a condition level is cited and the timeliness of revisits and desk reviews.

Recommendation 3

To ensure that investigations are conducted on a timely basis across priority levels, Public Health should develop and implement target time frames for the priority levels that lack them. Public Health should monitor to ensure that the timelines are being met, and if not, explore new ways to increase efficiency and manage its workload, thereby facilitating timely investigations.

Response 3

CDPH disagrees that it should develop and implement target timeframes for the priority levels that lack them. The Centers for Medicare and Medicaid Services (CMS) provides prioritization guidance on these lower level complaints and facility reported incidents. Per CMS, these include allegations which "may cause harm that is of limited consequences and does not significantly impair the individual's mental, physical, and/or psychosocial status or function." CDPH does have a policy to initiate immediate jeopardy complaints and facility reports within 24 hours and non-immediate jeopardy high complaints and facility reports within 10 days. ①

An integral part of prioritizing complaints and facility-reported incidents is making a clinical judgment of their severity. CDPH nurse surveyors and supervisors, using assessment skills learned in federal and state training and survey experience, triage and prioritize complaints and facility-reported incidents based on the information gathered during the intake, their understanding of the potential impact to the client/resident, their knowledge of the facility, and the significance of the possible regulatory violation. ②

**California Department of Public Health Response to Draft Report:
"Developmental Centers: Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk"
Report 2012-107 July 2013**

CDPH uses the CMS process and database to track complaints and facility-reported incidents. This database requires a target initiation date for each intake. Although CDPH and CMS policies do not have a prescribed target initiation date for some low priority
③ levels, CDPH generally assigns an initiation date of 45 days. CMS conducts performance reviews of our investigations, which includes reviewing whether we initiated an investigation within the timeframe assigned during the intake. CDPH
④ believes this process is sufficient to assign and monitor timelines.

Recommendation 4
To improve its enforcement, each year Public Health should evaluate the effectiveness of its enforcement system across all types of health facilities, particularly developmental centers, prepare an annual report, and, if called for, recommend legislation to improve the enforcement system and enhance the quality of care.

Response 4
CDPH agrees with this recommendation.

CDPH will identify an existing report or prepare a separate report to transmit this information to the Legislature.

Further, CDPH is contracting for an organizational assessment of the effectiveness and performance of the Licensing and Certification (L&C) program. This assessment will be completed in a two-step scope of work and will be completed by July 31, 2015. The first step will include an assessment of L&C's resources, mandates, performance, management processes, and organizational culture. The second scope of work will assess the findings from the first review and propose opportunities for L&C to implement operational efficiencies and best practices. Depending on the findings in the second assessment, CDPH may recommend proposed legislation to improve efficiencies.

If CDPH determines that legislation is need, we will follow our established process for recommending changes.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE HEALTH AND HUMAN SERVICES AGENCY, CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

To provide clarity and perspective, we are commenting on the response to our audit from the California Department of Public Health (Public Health). The numbers below correspond to the numbers we placed in the margin of Public Health's response.

Public Health correctly quotes a portion of the Centers for Medicare and Medicaid Services (CMS) guidance but neglects to address CMS guidance indicating that prevention is one of the objectives of the complaint and incident management system. As we discuss on page 66, federal guidance explains that the investigation of these events, even ones that are designated as less serious, is designed to identify and correct less serious issues to prevent them from becoming more serious problems. By not addressing lengthy delays in investigations—like some of the delays shown in Figure 7 on page 65—Public Health appears to be missing opportunities to prevent in a timely manner the potential escalation of problems within the developmental centers. (1)

Although we understand that clinical judgment is essential in the process of prioritizing complaints and facility reported incidents, we do not believe that this specialized expertise negates the need for accountability within Public Health. Thus, we stand by our recommendation on page 68 that Public Health establish target time frames across priority levels. (2)

The first we learned of Public Health's assertion that it generally assigns an investigation initiation date of 45 days from the date a low priority level incident is reported was in its response to this audit. In fact, during the course of our audit the chief of operations for Licensing and Certification maintained that there is no time frame within which Public Health must initiate investigations of these types of incidents. Consequently, we could not validate Public Health's claim that it generally assigns 45 days as the target for initiating investigations for these priority levels. However, if this truly does occur, Public Health appears to have established, at least informally, a target time frame for initiating investigations across priority levels. Therefore, we fail to understand Public Health's resistance to our recommendation. (3)

The portion of CMS's annual state performance reviews that directly relates to investigations does not include all of the types of facilities at the developmental centers, such as the intermediate care facilities for the developmentally disabled. Therefore, we believe it is essential (4)

for Public Health to monitor the investigation of all types of complaints and incidents, particularly for those facilities that are not included in CMS's formal performance reviews.

cc: Members of the Legislature
Office of the Lieutenant Governor
Little Hoover Commission
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press