Caregiver abuse cases puts Calif. patients at risk

By Ryan Gabrielson, Center for Investigative Reporting

California regulators routinely have conducted cursory and indifferent investigations into suspected violence and misconduct committed by hundreds of nursing assistants and in-home health aides – putting the elderly, sick and disabled at risk over the past decade.

In 2009, the state Department of Public Health quietly ordered its investigators to dismiss nearly 1,000 pending cases of abuse and theft – often with a single phone call from Sacramento headquarters. The closing of cases en masse came after officials determined their swelling backlog had become a crisis.

Four years later, state investigators are opening and closing investigations into suspected abuse without ever leaving their desks, the Center for Investigative Reporting and KQED have found. In some instances, caregivers who have sexually assaulted or abused patients have retained their licenses and moved to other facilities.

Brian Woods, former director of the Department of Public Health's West Covina office,

says don’t count on the government.
Photo/Adithya Sambamurthy/Center for Investigative Reporting

An estimated 160,000 nursing assistants and in-home health aides are employed throughout California. These workers — all regulated by the Department of Public Health — are certified to work in hospitals, nursing homes, mental health facilities, developmental centers and private homes.

Since the mass dismissal of cases in 2009, the overwhelming majority of allegations of abuse and misconduct have been closed without action. The state also has dramatically reduced the number of license revocations for aides suspected of abuse and misconduct.

And it mostly has stopped referring cases to the California Department of Justice for possible prosecution of crimes, according to state prosecutors and the Department of Public Health.

In addition, the department’s Southern California investigations office, which once had 11 full-time examiners, is nearly empty. Internal documents show abuse cases from Los Angeles, San Diego, Santa Barbara and Riverside mostly now go to Sacramento headquarters. There, investigators rarely receive approval from supervisors to visit nursing and group homes where abuse and neglect have been alleged.

For some who have worked in the system, the state has abandoned its duty to protect the vulnerable.

“I would tell anybody, do not count on the government taking care of you,” said Brian Woods, former director of the Department of Public Health’s West Covina office.

From 2004 to 2008, the state’s health regulators accumulated

more than 900 cases in Southern California, including alarming allegations that involve suspicious deaths.

“I was appalled,” said Marc Parker, who was the public health department’s investigations chief for much of the past decade. “There were hundreds and hundreds and hundreds of unassigned, uninvestigated complaints in file drawers.”

Then, on top of their normal workload, investigators were ordered by supervisors in Sacramento to begin clearing the backlog at a rapid pace, until they were nearly all dismissed by 2011. On average, cases had lingered for two years before they were cleared.

Little is known about theses cases because they were not fully investigated. But internal case logs kept by the state in Sacramento offer a chilling, yet faintly detailed outline of allegations – including suspicious deaths, severe injuries, numerous sexual assaults, egregious neglect and theft of belongings.

One log entry lists a caregiver who allegedly “hit, peed on and seduced” a patient, but does not list a facility, city or county. Another notes a nursing assistant at an unnamed Los Angeles facility who was accused of exposing himself and asking for oral sex from a resident. Both caregivers still are working at the facilities.

More than 230 log entries simply read “physical or sexual abuse” and little else beyond a date and county where the alleged incident took place.

Public health regulators have all but stopped alerting the California attorney general’s office of patient deaths alleged to involve abuse. The attorney general has an entire division – the Bureau of Medi-Cal Fraud and Elder Abuse, which has 41 lawyers – that specializes in prosecuting such cases. By law, health regulators are required to report all suspected crimes to the division.

From 2007 to 2009, the department referred a total of 88 deaths to state prosecutors for investigation into elder abuse, according to figures from the attorney general. During the following three years, that number dropped to 14.

Regulators sent two death cases to prosecutors in 2011 and three in 2012.

One case that has remained unsolved is the suspicious death in 2006 of Elsie Fossum, a 95-year-old woman who lived at Claremont Place Assisted Living in Southern California. Fossum was a teacher and librarian in eastern Los Angeles County for most of her life and moved into Claremont two years before she died.

Although she had been found severely injured on the floor of her bedroom, the California Department of Public Health dismissed it as an accidental fall from bed. The department closed the abuse allegation in February, classifying it as unsubstantiated.

With injuries to her mouth so severe that she stopped eating and drinking, Fossum died of dehydration in a hospice three weeks after she was found injured. A nursing assistant at the facility who was caring for Fossum at the time of her injuries — and who had made repeated disparaging remarks about the elderly woman, according to state records — quit soon after the injuries and took a similar job at a nearby facility.

Now, seven years after Fossum died — and following questions from reporters — the Los Angeles County Sheriff's Department has opened a criminal inquiry into the death. The case remains unsolved, and the nursing assistant, Sabrina Bengoa, has not been charged with a crime. She did not respond to requests for comment by phone or at her home.

"When you've got agencies looking at it, you figure they're going to find something if something's there," said Jim Fossum, Elsie's nephew, who lives in Brainerd, Minn. "Not that

they’d just put the thing away and forget about it, essentially.”

Records show the public health department rarely takes action even in the face of damning evidence. Under the administrations of Govs. Arnold Schwarzenegger and Jerry Brown, the number of nursing assistants and in-home health aides removed from the job for crimes against the sick and vulnerable has declined sharply.

In 2006, the department revoked or denied a caregiver’s certification in 27 percent of complaints it investigated. That figure shrank to 7 percent three years later as regulators eliminated the backlog.

Meanwhile, the number of cases closed without action has soared. Statewide, public health investigators in 2012 finished 81 percent of their cases without taking action against an accused caregiver, up from 58 percent in 2006.

The Department of Public Health is fixing how it handles allegations against nursing assistants, Anita Gore, an agency spokeswoman, said in a prepared statement. “Organization and operation of the Investigations Section, including Southern California, are currently being addressed.”

State officials said they can’t explain why there has been a steep drop in the number of abuse deaths forwarded to law enforcement.

“We don’t understand that decline in numbers,” said Dr. Ron Chapman, director of the Department of Public Health. “It’s very concerning to me, and we’re looking into it.”

Chapman said the backlog of cases was “inexcusable (and) should not have occurred.”

“We’ve made lot of progress since then,” he said. “So today, any complaints that come in, they get screened within 48

hours, and we're not building a backlog today."

Mark Zahner – California's chief prosecutor on elder abuse cases until August – said he had not asked the Department of Public Health why there are now so few cases. In an interview in April, he said he did not believe state regulators were withholding death cases.

"It would be weird," Zahner said, "because I don't see how that would do anybody any good."

Nevertheless, Paul Greenwood, head of the San Diego County district attorney's elder abuse unit, said public health regulators long have refused to provide his office cases to prosecute. The drop in abuse death cases sent to state prosecutors is shocking, Greenwood said, and worrisome.

"I don't know how many nursing homes there are in California or how many deaths a year there are in the facilities, but the number is going to be huge," Greenwood said. "And to think there are only two suspicious deaths, I just frankly cannot believe that."

Phoning it in

The Department of Public Health is in charge of keeping dangerous people out of the health care business.

In a well-run department, when there is an allegation of abuse, inspectors immediately should open a case, visit the facility, collect law enforcement records, interview people at the scene and make a determination about what happened. If they uncover abuse, the department is required to revoke the certification of any accused caregiver and report the matter to law enforcement and the attorney general's office.

Parker, the former investigations chief, said his boss, Evon Lenerd, wanted complaints closed efficiently and quickly. Lenerd ordered Parker's staff to conduct nearly all

investigations by phone, without visiting care facilities where abuse allegations have arisen.

But Parker said investigators find the most severe problems when they walk through health care facilities. They often find new cases that haven't been reported.

"Good investigators have big eyes," said Parker, who retired in December 2011.

Closing cases by phone is "just ridiculous," he said. "They're missing huge amounts of information. The job is not being done."

Listen to an insider's view

Marc Parker, the public health department's former investigations chief, talks about closing cases over the phone.

Lenerd, head of the professional certification branch, declined several interview requests.

The Department of Public Health denies directing investigators to close cases primarily by phone. "If preliminary phone calls and other reviews during a desk investigation determine a field component is warranted, then a field investigation is conducted," wrote Gore, the department spokeswoman.

She wrote that investigations have been delayed due to a "change in resources."

In July, the California State Auditor criticized the Department of Public Health for being slow to investigate allegations of misconduct at state institutions for the developmentally disabled.

Also, the department never has released a report detailing its enforcement activities, which state law mandates. Therefore, the auditor wrote, "the effectiveness of its enforcement

practices, particularly those related to developmental centers, remains uncertain.”

Investigative shortcomings, however, extend everywhere Californians receive care.

Internal state records and court files obtained by the Center for Investigative Reporting show the Department of Public Health has failed repeatedly to strip nursing assistants of their certification until years after confirming they had harmed patients.

Despite evidence of serious crimes, one of the least-active offices is the department’s southern branch, established to pursue allegations from Bakersfield to the Mexican border. Just off Interstate 10 in the suburbs east of Los Angeles, the investigations section is on the ninth floor of an office tower encircled by chain restaurants and retail.

The branch once employed 11 full-time investigators. It appeared deserted when reporters visited on a weekday afternoon in late July. No investigators were present; rows of cubicles sat empty. Another visit months earlier revealed a single person working in the office.

Chapman, the public health director, said there are supposed to be investigators working in Southern California. “As far as I know, there’s staff down south,” he said.

Even when employees filled the office, Southern California cases received little attention for years. A department examination in 2010 — written by Kim Krazynski, then the branch’s new investigations director — detailed disarray. She compared the branch to an engine to explain the problems’ severity.

“If a single factor is malfunctioning, the engine will misfire and organizational performance will suffer,” Krazynski wrote. “In the case of the Southern Region Office, all components

that make up the engine are either malfunctioning or are completely absent.”

One misfire came in March 2008, when nursing aide Jason Joslin physically abused one or more patients at a Riverside County health care facility, according to internal case logs. The department opened an investigation immediately. Details of the case were not available.

No action followed until November 2011, when the state spiked Joslin’s California certification and decided to add his name to the federal exclusion list, maintained by the U.S. Department of Health and Human Services’ inspector general to alert the public to bad caregiver.

The revocation came too late.

Joslin moved to Seattle in March 2010 and quickly obtained a temporary nursing assistant license from Washington state, regulatory records show. By August of that year, Joslin was fully credentialed in his new state.

Joslin did not respond to written interview requests sent by email and social media.

His license is active through mid-January 2014, and his record appears clear. The Department of Public Health has not yet included Joslin on the exclusion list.

Criminal convictions

Not even criminal convictions ensure swift action.

On Oct. 5, 2007, a 59-year-old female patient was lying awake on her bed at the Del Rio Sanitarium in Bell Gardens when Ricky Diocampo assaulted her. Diocampo, a nursing assistant, pushed his hands under the woman’s clothes to fondle her breasts and genitals, investigation records show.

The patient is diagnosed with schizoaffective disorder, a

debilitating mental illness that causes delusions and mood swings. Because of her mental health condition, she cannot legally consent to sex.

On that October day, a third person was in the bedroom. Another employee stood in a corner on a ladder, painting ceiling trim, when he made eye contact with Diocampo. His presence didn't deter the nursing assistant, records show.

Seven weeks after the assault was witnessed, the state Department of Public Health assigned the case to investigator Reginald Mitchell, who also was the investigator on the Elsie Fossum case.

A year passed before the attorney general's office filed three criminal charges against Diocampo, who was arrested and spent four days in jail. Two of the counts – for sexual assault and battery of an institutionalized person – require convicts to register as a sex offender. The third count was for abuse of a dependent adult.

Diocampo, under an agreement with the Los Angeles County district attorney's office in 2009, pleaded guilty to the patient abuse charge. He received two years of probation and wasn't designated a sex offender.

Diocampo remained an authorized California nursing assistant and home health aide for three months after his conviction, when his certificate expired. Such a deficiency can be explained to employers as a paperwork error with the state.

The criminal proceedings did nothing to spur Mitchell, the public health investigator, to strike Diocampo's certification, according to department case logs and email correspondence.

Mitchell did not check on the sexual assault case for almost two years after Diocampo pleaded guilty. A new supervisor took over the Department of Public Health's office in West Covina

in early 2011 and asked Mitchell for an update on his oldest open investigations – nine cases from 2006 and 2007.

Regarding the Diocampo case, Mitchell responded in a March 23, 2011, email that he was “waiting on a return call back” from the attorney general’s office.

The state revoked Diocampo’s certification five weeks later.

No significant regulatory hurdles blocked Diocampo from working with vulnerable patients during the three-and-a-half-year investigative delay. It is unknown whether he was employed at health care facilities during that period.

He was convicted of domestic violence in Los Angeles County in April 2012. Diocampo did not respond to calls and notes left at his home requesting an interview.

Diocampo is now on the federal exclusion list. Prospective employers quickly would learn that Diocampo is barred from working at health care facilities, should he apply in the future.

The public health department’s handling of these cases is unacceptable, said Parker, the former investigations chief. However, he added, with investigators today working cases primarily by phone, many abuses by nursing aides likely are closed with no action or never discovered.

Parker’s 2011 retirement after two decades with the department was an earlier exit than intended, he said, but he couldn’t abide by cursory reviews of violent crimes.

“I couldn’t stop what was happening,” he said, “and I couldn’t protect the public.”