DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date SEP 1 1 2000

From for June Gibbs Brown
Inspector General

Subject Safeguarding District of Columbia Residents who have Mental Retardation or other Developmental Disabilities: Responding to Reported Allegations of Abuse or Neglect (A-12-99-00008)

To Olivia A. Golden
Assistant Secretary
for Children and Families

This memorandum transmits the final report entitled "*Safeguarding District of Columbia Residents who have Mental Retardation or other Developmental Disabilities: Responding to Reported Allegations of Abuse or Neglect.*" This report provides a summary of our findings and recommendations resulting from our audit of District agencies' policies and practices for responding to allegations of abuse or neglect.

In May 1999, in response to concerns about violations of Mental Retardation and Developmental Disabilities Administration (MRDDA) customers' rights, the former Director of the District's Department of Human Services (DHS) requested assistance from the U.S. Department of Health and Human Services' Administration on Developmental Disabilities (DHHS/ADD), which oversees the States' (and the District's) implementation of systems to protect and advocate the rights of individuals with developmental disabilities. The DHHS/ADD contacted our office about audit work we could provide and we discussed a review of District agencies' response to allegations of abuse or neglect. After meeting with District officials, we decided to include the District in an ongoing review of States' practices for reporting, tracking and investigating allegations of abuse or neglect involving persons with disabilities.

We found that District agencies' policies and practices for receiving, tracking and investigating allegations of abuse or neglect, referred to as incidents by the District, did not provide adequate safeguards. Specifically, we found that District agencies were not adequately tracking or, in many instances, not promptly investigating reported incidents and that the existing policies and practices did not ensure that residential facility operators or other service providers always reported incidents. As a result of these deficiencies, we concluded that District residents receiving services from MRDDA have not been adequately protected and remain at risk until needed safeguards are implemented.

We recommended that the District:

- review current incident reporting requirements in policy statements, municipal regulations and contracts and, where necessary, make appropriate revisions, to ensure that providers receive clear, consistent guidance;

- ensure that District employees and provider staff receive periodic training in incident reporting;

- enforce incident reporting requirements during periodic site reviews;

- ensure that there is a timely investigation of serious incidents and that all deaths are subject to review by an independent body;

- develop performance standards, time frames and guidelines for District employees resolving or investigating reported incidents;

- make implementation of automated tracking systems a priority and ensure that incidents are tracked through corrective action. Agencies should also maintain databases of reported incidents to facilitate identification of systemic problems;

- develop a policy on use of restraints and other behavior management techniques, such as "time-out" procedures, which includes provider documentation and reporting requirements. Also, establish training requirements for facility staff;

- consider establishing an abuse registry covering all care staff,

- provide periodic management reports to senior District officials on the number and type of incident reports received, investigations conducted, and substantiated cases of abuse or neglect, and

- establish a central reporting point for providers to report incidents and the public to report complaints.

By letter dated August 10, 2000, the District generally concurred with our recommendations and provided details on actions its agencies are taking to improve services and establish needed safeguards. We recognize that to make substantive changes, District agencies must not only adopt new policies and procedures but effectively

implement them. We are providing a copy of this report to the D.C. Office of Inspector General to assist them in conducting a follow-up audit.

Any questions or comments you may have concerning any aspect of this audit are welcome. Please call me or have your staff contact Joseph J. Green, Acting Assistant Inspector General for Administrations of Children, Family, and Aging Audits at (301) 443-3582.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

SEP 11 2000

The Honorable Anthony A. Williams
Mayor of the District of Columbia
Washington, D.C. 20001

Dear Mayor Williams:

Enclosed are two copies of our final report entitled "*Safeguarding District of Columbia Residents who have Mental Retardation or other Developmental Disabilities: Responding to Reported Allegations of Abuse or Neglect.*" This report provides a summary of our findings and recommendations resulting from our audit of District agencies' policies and practices for responding to allegations of abuse or neglect.

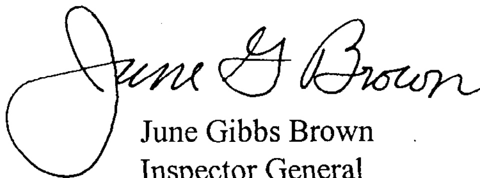
We found that District agencies' policies and practices for receiving, tracking and investigating allegations of abuse or neglect did not provide adequate safeguards. Specifically, we found that District agencies were not adequately tracking or, in many instances, not promptly investigating reported incidents and that the existing policies and practices did not ensure that residential facility operators or other service providers always reported incidents. As a result of these deficiencies, we concluded that District residents receiving services from the Mental Retardation and Developmental Disabilities Administration have not been adequately protected and remain at risk until needed safeguards are implemented. Our recommendations are focused on these safeguards.

We appreciate the District's thorough response to our draft report which detailed the actions the District is taking to improve service delivery and establish needed safeguards. We recognize that to make substantive changes, District agencies must not only adopt new policies and procedures but effectively implement them. We are providing a copy of this report to the D.C. Office of Inspector General to assist them in conducting a follow-up audit.

We would appreciate your views and the status of any further actions taken on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact Joseph J. Green, Acting Assistant Inspector General for Administrations of Children, Family, and Aging Audits at (301) 443-3582.

To facilitate identification, please refer to Common Identification Number A-12-99-00008 in all correspondence relating to this report.

Sincerely yours,



June Gibbs Brown
Inspector General

Enclosures

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SAFEGUARDING DISTRICT OF COLUMBIA RESIDENTS WHO HAVE MENTAL RETARDATION OR OTHER DEVELOPMENTAL DISABILITIES: RESPONDING TO REPORTED ALLEGATIONS OF ABUSE OR NEGLECT

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 2000
A-12-99-00008

EXECUTIVE SUMMARY

Much has been written about problems in services provided for District of Columbia (D.C.) residents who have mental retardation or other developmental disabilities. In January 2000, the Department of Justice (DOJ) publicly released a series of reports focused on shortcomings in services and safeguards for some residents. Also, in January the D.C. Government released its own report that was equally critical of services being provided.

Our review, which focused on how District agencies receive and respond to allegations of abuse or neglect of persons receiving services from the Mental Retardation and Developmental Disabilities Administration (MRDDA), in large part, corroborates previously reported problems. We found that District agencies' policies and practices for receiving, tracking and investigating allegations of abuse and neglect, referred to as unusual incidents by District agencies, did not provide adequate safeguards. Based on our evaluation of policies and practices during 1999, we found that District agencies did not have an adequate system for responding to reported incidents. As a result of these deficiencies, we concluded that District residents receiving services from MRDDA have not been adequately protected and remain at risk until needed safeguards are implemented. Our recommendations are focused on these safeguards.

Some of the incident reports we reviewed reflected serious and avoidable abuses of vulnerable persons and justifiably raise concerns about the quality of services and adequacy of safeguards in place. However, we also found instances in which District employees responded promptly and appropriately to reported incidents. We think it is important to recognize that providing quality services and ensuring safeguards is a demanding job made more difficult by staff shortages, lack of training and limited resources.

We are concerned that the deficiencies we are reporting are long-standing and have persisted despite several unique safeguards in the District. These safeguards have included ongoing involvement by the DOJ on behalf of some persons receiving services from MRDDA; oversight by a Special Master appointed by a Federal Court; a MRDDA Human Rights Committee that includes community representatives, and a Quality Assurance Committee comprised of District agencies and the local protection and advocacy group.

Scope of Review

In May 1999, in response to concerns about violations of MRDDA customers' rights, the former Director of the District's Department of Human Services (DHS) requested assistance from the U.S. Department of Health and Human Services' Administration on Developmental Disabilities (DHHS/ADD), which oversees the States' (and District's) implementation of systems to protect and advocate the rights of individuals with developmental disabilities. The DHHS/ADD

contacted our office about audit work we could provide and we discussed a review of District agencies' response to allegations of abuse or neglect. After meeting with District officials, we decided to include the District in an ongoing review of States' practices for reporting, tracking and investigating allegations of abuse or neglect involving persons with disabilities.

The DHHS funds a variety of programs at the State level that play a role in handling allegations of abuse or neglect. Intermediate care facilities for the mentally retarded (ICFs/MR) and long-term care facilities, both funded by the Federal Medicaid program, are subject to Federal conditions of participation and to survey and certification requirements. For ICFs/MR, this includes the requirement that the client not be subjected to physical, verbal, sexual or psychological abuse or punishment and specifically requires these facilities to report allegations of abuse or neglect in accordance with State law. Similarly, for long-term care facilities, residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.

The DHHS/ADD provides a grant for the District's protection and advocacy program, which investigates allegations of abuse or neglect, as called for in the Developmental Disabilities Assistance and Bill of Rights Acts. The Long-term Care Ombudsman program, also funded by a grant from DHHS, identifies, investigates, and resolves complaints by or on behalf of long-term care residents. The District's Adult Protective Service, which is funded in part by a DHHS block grant, also responds to reported allegations of abuse or neglect involving persons in need of protection.

Whenever possible we work with other audit organizations. In this instance, we worked with the D.C. Office of Inspector General (D.C. OIG) and agreed on an audit plan that would cover both District agencies and service providers. We focused on the roles and responsibilities of District agencies in responding to reported incidents. The D.C. OIG, who will issue its own report, planned to focus on contracting issues, including determining whether residential facility operators and others provided services specified in contracts.

Summary of Findings

We found that District agencies were not adequately tracking or, in many instances, not promptly investigating reported incidents and that the existing policies and procedures did not ensure that residential facility operators or other service providers always reported incidents.

Based on the results of our review, we found that:

- Many incidents were not investigated. Of the 65 incidents we reviewed, a field investigation was conducted on 14 by a District agency. However, some incidents were reviewed or investigated by more than one agency since the District has no process for determining which agency should take the lead in an investigation.

- District agencies did not have operational tracking systems capable of tracking an incident from receipt through corrective action and did not have databases of reported incidents to facilitate the identification of systemic problems.

- District agencies did not have adequate, up-to-date policies and procedures, performance standards and other guidance for employees receiving, resolving or investigating incidents.

- Until early 2000, there was no law that required ICFs/MR and community residence facilities to report allegations of abuse or neglect to MRDDA or DOH. However, there is no similar law applicable to day program operators, independent transportation service providers or foster homes.

Recommendations

We recommend that District agencies:

- review current incident reporting requirements in policy statements, municipal regulations and contracts and, where necessary, make appropriate revisions, to ensure that providers receive clear, consistent guidance;

- ensure that District employees and provider staff receive periodic training in incident reporting;

- enforce incident reporting requirements during periodic site reviews;

- ensure that there is a timely investigation of serious incidents and that all deaths are subject to review by an independent body;

- develop performance standards, time frames and guidelines for District employees resolving or investigating reported incidents;

- make implementation of automated tracking systems a priority and ensure that incidents are tracked through corrective action. Agencies should also maintain databases of reported incidents to facilitate identification of systemic problems;
- develop a policy on use of restraints and other behavior management techniques, such as "time-out" procedures, which includes provider documentation and reporting requirements. Also, establish training requirements for facility staff;

- consider establishing an abuse registry covering all care staff,

- provide periodic management reports to senior District officials on the number and type of incident reports received, investigations conducted, and substantiated cases of abuse or neglect.

Finally, we recommend that the District establish a central reporting point for providers to report incidents and the public to report complaints. This central point could: (1) maintain the database of incidents from receipt through final action; (2) screen incidents and do a risk assessment to determine the most appropriate agency to conduct an investigation; (3) handle distribution of incident reports; (4) follow up on the status and outcome of investigations and recommended corrective actions; and (5) do profiling of reported incidents to identify systemic problems.

District of Columbia's Comments and OIG Response

In its August 10, 2000, response to our draft report, the District generally concurred with our recommendations and provided detailed comments on actions taken or planned to implement needed safeguards. Based on the information provided by the District, we made minor changes to this report to clarify District processes. These changes did not affect the reported findings or recommendations. Comments from the District to our draft report are included in their entirety in Appendix A. With agreement from District officials, we have not reproduced the draft policy referenced in the District's comments. When finalized, the referenced policy will be available directly from the District.

We appreciate the District's thorough response to our report. We recognize that to make substantive changes, District agencies must not only adopt new policies and procedures but effectively implement them. We are providing a copy of this report to the D.C. Office of Inspector General (D.C. OIG) to assist them in conducting a follow-up audit.

****

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Department of Health and Human Services, Office of Inspector General, Office of Audit Services reports are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (See 45 CFR, Part 5.)

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

INTRODUCTION 1

Background 1

Objective, Scope, and Methodology 2

FINDINGS AND RECOMMENDATIONS 5

Reporting Incidents 7

Incident Reporting Requirements 7
Shared Understanding of Reporting Requirements 8
Enforcement of Reporting Requirements 9
Case Manager's Disposition 10

Tracking Incidents 11

Investigating Incidents 14

Policies and Procedures 16

Additional Safeguards 17

Mortality Review 17
Protecting MRDDA Customers during Investigations 18
Restraints 18
Nationwide Criminal Background Checks of Care Staff and an Abuse Registry 19
Independent Party to Assist in Filing Complaints 20
Notification of Family Members, Guardians, and Attorneys 21
Mandatory Reporters 21

Other Recommendations 22

Centralized Incident Reporting and Tracking 22
Independent Investigative Agency 22
Case Files 23

DISTRICT OF COLUMBIA'S COMMENTS AND OIG RESPONSE 23

APPENDIX

INTRODUCTION

Background

Several District agencies share responsibility for receiving, tracking, and investigating allegations of abuse or neglect of persons with mental retardation or other developmental disabilities. The following agencies have primary responsibility for handling allegations of abuse or neglect:

- The Department of Human Services (DHS), Mental Retardation and Developmental Disabilities Administration (MRDDA), provides residential and/or case management services to approximately 1,550 District residents. The MRDDA refers to the people it serves as its customers. About half of MRDDA's customers reside in federally-funded intermediate care facilities for persons with mental retardation (ICFs/MR) or nursing homes. The other customers reside in community residence facilities (CRFs), foster homes, supervised apartments, and natural homes. The MRDDA has also placed a small number of customers in out-of-State facilities.

- The Department of Health (DOH), Licensing Regulation Administration (LRA), administers all District and Federal laws and regulations governing the licensing and certification of health care and social services facilities. Our review covered two LRA divisions. The Health Facilities Division has oversight of ICFs/MR, hospitals, and nursing homes. This Division also acts as the State survey and certification agency for Medicare/Medicaid programs and is responsible for following Health Care Financing Administration (HCFA) guidelines in handling complaints of abuse or neglect. The Human Services Facilities Division oversees CRFs housing persons with mental retardation or mental illness or who are seniors and need supervised living arrangements.

- The DHS, Office of Investigations and Compliance (OIC), is responsible for conducting investigations for DHS agencies, including MRDDA. The OIC conducts investigations of reported incidents and has been designated the focal point to coordinate investigations of allegations involving criminal acts.

Other District agencies that may also receive and respond to allegations of abuse or neglect, include the DOH, Medicaid Assistance Administration (MAA), the DHS, Adult Protective Service (APS), the Child and Family Services Agency, and the D.C. Metropolitan Police.

Approximately one-half of MRDDA's customers are also subject to monitoring by a court representative. This monitoring requirement is pursuant to a Federal class action law suit representing residents of the District's institution which was closed in 1991.

The rights of MRDDA customers are protected under Federal and District laws and regulations. Among these rights, is the right to be free from mistreatment, abuse, neglect or unnecessary restraint. About half, or approximately 780, of MRDDA's customers reside in federally-funded facilities subject to the HCFA conditions of participation. The other customers reside in facilities subject only to District municipal regulations or in natural homes. Within this framework, District agencies develop internal operating policies and procedures for handling allegations of abuse or neglect and each residential facility operator or other provider develops operating policies and procedures to prevent abuse or neglect.

Objective, Scope, and Methodology

The objective of our review was to evaluate whether the process used by District agencies to resolve allegations of abuse or neglect provided adequate protection to persons with mental retardation or other developmental disabilities.

In May 1999, in response to concerns about violations of MRDDA customers' rights, the former Director of the District's Department of Human Services (DHS) requested assistance from the U.S. Department of Health and Human Services' Administration on Developmental Disabilities (DHHS/ADD), which oversees the States' (and District's) implementation of systems to protect and advocate the rights of individuals with developmental disabilities. The DHHS/ADD contacted our office about audit work we could provide and we discussed a review of District agencies' response to allegations of abuse or neglect. After meeting with District officials, we decided to include the District in an ongoing review of States' practices for reporting, tracking and investigating allegations of abuse or neglect involving persons with disabilities.

The DHHS funds a variety of programs at the State level that play a role in handling allegations of abuse or neglect. Intermediate care facilities for the mentally retarded (ICFs/MR) and long-term care facilities, both funded by the Federal Medicaid program, are subject to Federal conditions of participation and to survey and certification requirements. For ICFs/MR, this includes the requirement that the client not be subjected to physical, verbal, sexual or psychological abuse or punishment and specifically requires these facilities to report allegations of abuse or neglect in accordance with State law. Similarly, for long-term care facilities, residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.

The DHHS/ADD provides a grant for the District's protection and advocacy program, which investigates allegations of abuse or neglect, as called for in the Developmental Disabilities Assistance and Bill of Rights Acts. The Long-term Care Ombudsman program, also funded by

a grant from DHHS, identifies, investigates, and resolves complaints by or on behalf of long-term care residents. The District's Adult Protective Service, which is funded in part by a DHHS block grant, also responds to reported allegations of abuse or neglect involving persons in need of protection.

Allegations of abuse or neglect are among the occurrences that District agencies refer to as unusual incidents (incidents). We reviewed operating policies and procedures, listings of incidents, incident reports, and case management records provided by MRDDA. The DHS and DOH General Counsels assisted in obtaining copies of District laws and municipal regulations for our review. Most field work was conducted at MRDDA's office and at other District agencies. We also visited a small number of residential facilities to review records that were not maintained by MRDDA.

In total, we scanned listings of about 560 incidents and read over 200 incident reports to select our sample. Although we were unable to determine whether the listings of incidents or the incident reports provided by MRDDA which we used to select our sample, represented all reported incidents because MRDDA did not establish accountability over reports received, we believe that the sample drawn is sufficient for evaluating District agencies policies and practices for handling incidents.

We judgmentally selected 65 incidents from the reported incidents received by MRDDA from January - October 1999. Initially, we selected a sample of 42 incidents involving 36 MRDDA customers that were logged by MRDDA from January - July 1999. The difference between the number of reports and customers is because some customers had multiple incidents during the period. We purposely included incidents that involved allegation of abuse or neglect by care staff, use of restraints, reports of deaths or involved customers with multiple reported incidents. We selected a second sample of 23 incidents reports involving 18 customers received by MRDDA during August - October 1999 so that we could consider the impact of organizational changes in handling incident reports made by MRDDA in the second half of Calendar Year (CY) 1999.

At other District agencies that receive referral of incident reports from MRDDA for action or may independently receive incident reports, we interviewed managers and staff that played a role in handling incidents, reviewed policies and procedures provided by these agencies and followed the sample of incidents selected from MRDDA records through final action by each of these agencies. We did not review D.C. Metropolitan Police investigation records because we lacked authority to do so.

We also met with representatives of the D.C. Protection and Advocacy group, University Legal Services, the Office of the D.C. Long-term Care Ombudsman, and a court-appointed monitor to gather additional background information.

As noted earlier, our audit in the District has been conducted concurrently with a nationwide review of how States safeguard persons with disabilities. The nationwide review, covering six States and the District, began in Massachusetts in early 1999 and has focused on identifying specific policies and practices States have adopted to safeguard persons with disabilities. We considered policies and practices some of these States have adopted in preparing this report.

Whenever possible, we work with other audit organizations. In this instance, we worked with the D.C. OIG and agreed on an audit plan that would provide a comprehensive look at some of the services provided by District agencies and contracted providers. We focused on the roles and responsibilities of District agencies in responding to reported incidents. The D.C. OIG, who will issue its own report, planned to focus on contracting issues, including determining whether residential facility operators and others provided services specified in contracts.

Our work was conducted in accordance with generally accepted government auditing standards. We began our review in the District in mid-June 1999 and finished field work at the District agencies in December 1999. We held completion of this audit because records of the primary investigative agency, DHS/OIC, were seized by the D.C. Metropolitan Police in December 1999, and that agency was unable to provide requested documentation until March 2000. Because of changes in District agency personnel, policies and procedures after completion of our field work but before this report was issued, we updated our understanding of relevant policies and procedures through March 2000, but did not determine whether the revised policies and procedures had been placed in operation or whether they would be effective.

We are aware that District agencies that provide services or safeguards to persons with disabilities are changing the way they operate, including implementing new policies and practices. Some of these changes were self-initiated, while others are in response to externally identified problems and criticisms. In some instances, we are aware of specific actions taken by these agencies and have acknowledged these efforts. In other instances, we have been told that corrective actions are being taken but have not been provided sufficient details to comment on these planned actions. It is encouraging that the District has evidenced a commitment to aggressively pursue corrective actions to improve its policies, procedures and practices. However, the changes that District agencies are making must ultimately reflect a long term commitment to improving services.

We conducted this review with the cooperation and assistance of District employees, provider staff and other groups. Everyone shared both their time and knowledge and we appreciate their cooperation and assistance.

FINDINGS AND RECOMMENDATIONS

Based upon our evaluation of policies and practices in place during 1999, we found that District agencies did not have an adequate system for responding to reported incidents. We found that District agencies were not adequately tracking or, in many instances, not promptly investigating and resolving incidents, and the existing policies and procedures did not ensure that residential facility operators or other service providers always reported incidents. As a result of these deficiencies, we concluded that District residents receiving services from MRDDA have not been adequately protected and, until needed safeguards are implemented, remain at risk.

Following are examples of the incidents involving MRDDA customers that led us to these conclusions:

- A woman's eye was removed because of a serious infection. The woman was hospitalized because of a "corneal perforation" according to the physician's notes. The physician's notes further describe symptoms identified by the residential provider at admittance as malaise, decreased appetite and crusting of lids and draining from the eye. MRDDA records indicate that the incident was referred to OIC in May 1999, however, OIC stated that it did not receive a copy of this incident report. There is no indication that an investigation was performed to determine the cause of the injury or to determine whether the woman received prompt medical treatment for the injury prior to removal of the eye.

- A woman was alleged to have been physically abused by care staff on June 4, 1999. The incident report and other documentation refers to multiple bruises on the woman's shoulder and thigh. The residential provider investigated the incident and terminated an employee; two other employees resigned. The MRDDA requires providers to immediately report instances of alleged physical abuse to the D.C. Metropolitan Police. The incident report the provider filed with MRDDA does not indicate that this notification was made and there is no evidence of the notification on the case manager's disposition form. We also noted that there were four documented instances of "bruising" to this woman prior to the June 4th incident that were not reported to MRDDA. We also noted unreported incidents after the June occurrence.

- Another woman was beaten with a plastic baseball bat by day program care staff in November 1998. The day program did not file the required incident report. The incident report filed by the residential provider reported that the woman was injured during a "physical restraint." The hospital treating the woman contacted the D.C. Metropolitan Police. The day program operator subsequently terminated two employees -- one

employee was terminated a month after the incident; the other employee was terminated more than 2 months after the incident. There was no indication of whether the day program placed these employees on administrative leave or took other action to safeguard customers until they were terminated. Both employees were arrested in February 1999.

- A woman had 5 reported injuries according to a listing provided by MRDDA. These incidents were described as "physical injury", "injury to knee", and 3 instances of "scratches." MRDDA could not locate three of the incident reports and we found no evidence that any of these incidents were investigated by a District agency.

- Two men died after hospitalizations for pneumonia. There was no investigation to determine whether either man was receiving adequate medical care prior to illness that led to their hospitalization.

- A man with a history of reported, but unsubstantiated, sexual abuse by a family member, was alleged to have sexually molested a woman while being transported in August 1999. Both were MRDDA customers. The woman was allowed to continue riding on the same van with the alleged molester for a month until a change in transportation providers was made. A February 2000 OIC draft investigation report found that the van driver and escort were aware of the incident but failed to file a report. The draft report also indicated that the man had "been involved in previous sexual behavior with other MRDDA customers."

- A woman reported inappropriate sexual contact by a male care worker that likely occurred on or before August 12, 1999. The woman was not taken for a medical examination until August 17 and was not examined at that time because "she had been unable to tell the date of the alleged incident." An examination was finally conducted on August 19. The case was investigated but not pursued by the D.C. Metropolitan Police apparently because the woman, who has a mental age of a 6-year old, gave "conflicting accounts of the incident and there was no other witness to the incident." The care worker was terminated by the provider. The DOH/LRA report indicated that the facility was cited for failing to obtain a police clearance before allowing the worker to care for customers.

- A health care worker, visiting a foster home in early May 1999, reported to the MRDDA case manager that there was a padlock on the customers' bedroom door. The case manager visited the home on June 1 and was denied entrance by a teenage boy who was alone with two customers. Further, documentation provided by MRDDA indicated that it was not until a week after that visit that the case manager gained entrance to the residence and determined that "there was no padlock on the bedroom door or any evidence of a padlock ever being on the door." However, the provider did tell the case manager that she "does lock the door on occasion to 'protect' the customers." During the visit, the case manager found that one of the customers had "large scratches on her face" that had not

been reported by the provider who attributed the injury to self-abusive behavior. The case manager suggested that a behavior management plan be prepared for the customer. The provider agreed but expressed doubt that the customer could benefit from a plan due to their cognitive level. The OIC which received information about this incident in early June had not completed its investigation by mid-March 2000.

Reporting Incidents

During CY 1999, District agencies relied on the distribution of agency policy statements, memorandum and, in some cases, through contract provisions to make providers aware of the need to report incidents. Further, DHS and DOH did not consistently define reportable incidents. Existing incident reporting policies and procedures were not always followed by providers and there is little indication that providers were cited for untimely submissions or unreported incidents.

Incident Reporting Requirements

The MRDDA relied on the dissemination of reporting requirements detailed in two policy statements, one dating to 1984 and the other dating to 1992. The DOH, LRA relied on an annual letter to communicate its incident reporting requirements to federally-funded facilities providing residential services to about one-half of MRDDA's customers. The listing of reportable incidents in the MRDDA policy statements was different from the listing in the DOH letter. Based on our interviews with MRDDA case managers and a small number of providers' staff, it was also evident that some case managers and providers' staff made their own determination of what was a reportable incident.

Representatives of the facilities we visited indicated that they did not forward reports of each documented incident to MRDDA or other District agencies. That is, while the facility staff prepared an incident report or otherwise documented the occurrence in facility records, the information was retained at the facility for review by DHS or DOH staff during site visits.

The MRDDA policy called for providers to submit most incident reports within a day of the occurrence. Timely submission of an incident report is critical for MRDDA to take action to safeguard the customer and for an investigative agency to gather facts and probe witness accounts. However, there were delays of at least 5 days in the receipt of 19 of 131 incident reports based on a listing provided by MRDDA's Bureau of Program Operations and Contracts. Reliable information was not available to estimate the number of untimely incident reports in the remaining population of 426 reported incidents. Also, incident reports received by MRDDA were of varying quality and completeness. For example, many reported injuries lacked detail on the extent of the injury making it difficult for MRDDA case managers and others to readily determine the seriousness of the occurrence. Incidents reports also varied because some providers developed and submitted their own incident reporting forms.

District agencies recognized that unreported incidents existed and that there was a need for consistent and legally enforceable incident reporting requirements. At the end of December 1999, the DOH and DHS jointly issued a revised policy statement that modified the list of reportable incidents and changed how facilities notified MRDDA and DOH/LRA when an incident occurred. The revised policy also included a revised incident reporting form.

Also, as previously noted, the District amended its municipal regulations applicable to ICFs/MR and CRFs to cover incident reporting. Beginning in January 2000, these providers are required to notify the DOH/LRA of "... any other incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk." The DOH can assess civil fines for violation of this regulation. Enactment of this regulation provides an important safeguard to customers in residential settings. However, there is no similar regulation covering day programs attended by most MRDDA customers, transportation service providers, or foster homes although case manager dispositions and investigation reports revealed serious unreported incidents at these providers.

Issuance of a joint policy on incident reporting is an improvement over past practices in which each agency issued its own guidance to providers. Similarly, issuance of a legally enforceable municipal regulation was important. However, similar to earlier efforts to establish an incident reporting policy, the revised policy statement and the municipal regulation do not have consistent definitions of reportable incidents. For example, the municipal regulation specifies that the "sudden death of a resident" is a reportable incident; whereas, the joint policy statement simply refers to "deaths." Also, the revised municipal regulation does not specify that behavior management interventions such as the use of restraints is a reportable incident whereas the revised policy does. This inconsistent guidance promotes a misunderstanding of what incidents need to be reported.

The DHS and DOH had been adding language relating to incident reporting to provider contracts to reinforce reporting responsibilities. Existing contract language is not consistent with the revised reporting requirements and will need to be revised when contracts are issued or renewed.

Shared Understanding of Reporting Requirements

Among other things, providers are expected to report instances of physical, sexual or verbal abuse. However, if facility operators or the on-duty care staff do not recognize a practice or occurrence to be abusive or an indicator of potential abuse, they will not report it. One of the practices other States identified as facilitating incident reporting is a shared understanding of what is a reportable incident through the use of standard definitions. For example, from our work in the District and other States, we have found that there is no consistent understanding of what constitutes a "chemical restraint,"e.g., medication that can be appropriately used as part of a treatment plan can also, depending on the dosage, be used as a restraint. However, the District

recently added a requirement that facilities report the use of restraints, including chemical restraints, as an incident but did not provide guidance on what is considered a restraint.

The DHS and DOH will also have to ensure that facility operators and care staff are aware of and understand incident reporting requirements. The revised incident reporting policy specifies that care staff receive quarterly training from the provider in incident reporting but the amount and content of the training is left to the judgement of the provider. Based on case manager disposition forms and investigative reports we reviewed, some providers apparently were unaware of incident reporting requirements. Training sessions conducted by District employees, such as the training session on incident reporting recently held by MRDDA and the training session held by the DOH in September 1999, can be effective tools in communicating reporting requirements. However, if MRDDA relies on each provider to train its staff, MRDDA should monitor some training sessions to ensure that consistent guidance is communicated to care staff.

Site visits by MRDDA case managers, program monitors and DOH inspectors are another safeguard in identifying unreported incidents and reinforcing incident reporting requirements. It is essential that agency staff provide consistent guidance to facilities on incident reporting. As such, agencies need to ensure that their staff receive training in incident reporting requirements.

Enforcement of Reporting Requirements

Stringent, consistent enforcement of incident reporting is essential to ensure that MRDDA customers are safeguarded.

As noted earlier, the providers we visited indicated that they documented but did not report each incident to MRDDA or other District agencies. Our impression was that facilities believed that they were complying with MRDDA reporting requirements because they considered certain incidents to be less serious and felt it was sufficient to document the occurrence in facility records.

We also noted that MRDDA records indicated that some providers were not aware of reporting requirements. For example, an alert prepared by a case manager contained the following comment "this case manager only received the UI [unusual incident report] from [a large day program provider] after contacting [the provider] and becoming verbally assertive about the need to receive a report." The case manager reported that the provider was under the assumption that all incidents can be reported as late as seven days after the actual incident. The provider provided a revised version of the incident report approximately 3 weeks after the incident which involved alleged abuse by transportation staff.

Further, we saw no indication in the MRDDA records we reviewed, that these facilities were cited for unreported incidents. It is essential that MRDDA staff check compliance with reporting requirements during facility visits and notify DOH of instances of noncompliance so civil fines

and penalties can be assessed. Its also important that DHS and DOH make sure that the facility operator and care staff immediately receive refresher training on incident reporting requirements.

We made an effort to select incident reports from all types of facilities for our review, but noted few incidents reported for customers placed in nursing homes and in out-of-State facilities. Although MRDDA had not placed a large number of its customers in these facilities, additional effort is needed to ensure that these facilities are aware of and comply with incident reporting requirements. It is our understanding that MRDDA also noticed that few incident reports were being submitted by nursing homes and plans to pay close attention to these facilities.

Case Manager's Disposition

The timely response by a MRDDA case manager to a reported incident is an important safeguard. However, we were able to identify little written guidance to case managers on what actions they were expected to take when an incident report was received. When asked, MRDDA supervisors indicated that case managers use "professional judgement" in deciding what needs to be done when an incident report is received..

During the period covered by our audit, MRDDA case managers were required to complete a "disposition of unusual incident" form that detailed what actions they took in response to the reported incident and whether additional actions by the provider or by another District agency was needed to resolve the incident. This form was to be completed within 14 days of receipt of the incident report; however, disposition forms on 12 of the 65 incidents reviewed were not completed within the required time. In 4 of these instances, the case manager signed off on the disposition at least 2 months after the date of the incident. We could not determine the timeliness of an additional 13 dispositions because the form was undated or was not provided.

Based on our observations, we believe more detailed guidance and performance standards for case managers are needed and that performance be monitored. For example, earlier in this report we noted an instance in which a case manager followed up on a potentially serious, ongoing incident involving violation of customers' rights at least 3 weeks after receiving the initial report. We also noted instances in which the extent of the case manager's disposition was to follow-up with facility staff by phone or to request additional information from the provider. We noted fewer instances in which the case manager documented a face-to-face meeting with the customer immediately after the occurrence of an incident. We are not suggesting that actions taken by the case manager on each incident rise to the level of an investigation but that MRDDA establish guidelines, including guidelines for the use of "fact-finding" or investigative reports submitted by providers. For example, in the case of a reported injury, MRDDA should have guidelines on when the case manager makes a site visit to confirm that the injury was accurately reported and that the customer is receiving appropriate care or medical treatment.

Guidelines should also address what actions case managers take when an incident involves a customer placed in an out-of-State facility. These customers remain the responsibility of

MRDDA. Although MRDDA does not have a large number of out-of-State placements, these customers are entitled to the same protection.

Recommendations: We recommend that:

1. The DHS and DOH review current incident reporting requirements in policy statements, municipal regulations and contracts and, where necessary, make appropriate revisions, to ensure that providers receive consistent guidance.

2. Incident reporting requirements be added to municipal regulations covering all providers, including day programs and transportation service providers.

3. The DHS and DOH develop standard definitions for terms used in incident reporting guidance.

4. The DHS and DOH ensure that agency and provider staff receive periodic training in incident reporting.

5. The DHS and DOH determine whether providers adhere to the recently revised incident reporting requirements during periodic site reviews and be more diligent in identifying unreported incidents. The MRDDA should direct its case managers to notify DOH of instances of noncompliance so civil fines and penalties can be assessed where appropriate. We also recommend that MRDDA staff pay special attention to incident reporting during visits to nursing homes and out-of-State facilities.

6. The MRDDA develop performance standards and guidelines for case managers. The MRDDA should provide case managers with guidance on what actions are to be taken in response to a reported incident and monitor case manager performance with these guidelines. We would suggest that case manager supervisors make unannounced follow-up visits at facilities with major incidents or numerous incidents to ensure that case manager disposition guidelines are adequate and are being followed.

Tracking Incidents

During CY 1999, District agencies did not have operational systems capable of tracking incidents from receipt through corrective action and did not have complete databases of previously reported incidents to facilitate the identification of systemic problems. Without a dependable way to track and monitor the resolution of reported incidents, there is less chance that District agencies can find or remove negligent care staff, change provider procedures or identify parts of the service delivery system needing improvement.

Following is a description of how District agencies tracked incidents along with our observations:

MRDDA. In early 1999 MRDDA began trying to centralize the receipt and control of incident reports in the Bureau of Case Management and had directed providers to send incident reports to this office. However, some providers continued to send incident reports directly to case managers. Responsibility for tracking incidents was shifted to the Bureau of Program Operations and Contracts in August 1999 and efforts to centralize the receipt of incident reports continued.

Both Bureaus maintained listings of incidents received in their respective offices. We used information from these listings, in part, to select incident reports for review and to do some simple profiling of the type, frequency and source of incidents. Even though the amount of information available about reported incidents was limited, we found it useful in identifying potentially systemic problems in service delivery, such as customers with multiple incidents or providers with a large number of similar incidents, and encourage MRDDA to make implementation of an automated tracking system a priority. A functional tracking system becomes more critical as the number of incident reports increase due to MRDDA's efforts to ensure that providers adhere to reporting requirements.

We determined that the listings of incident reports provided were incomplete. We found that 10 of the 65 incident reports we reviewed were not on the listings indicating that MRDDA managers had not been able to establish initial accountability over all reported incidents. Although the systems that produced the listings may have been discontinued, data entry errors can occur in any system, and MRDDA will need controls to ensure that all data is entered completely and correctly.

We also noted four instances in which the DOH/LRA had a copy of an incident report that was not on the listings provided by MRDDA. We requested copies of these incident reports from MRDDA on two occasions but have not received a response. As such, we cannot determine whether the incident report had been received at MRDDA and not tracked or whether the provider had not reported the incident to MRDDA. This is a more serious problem. However, since DOH/LRA and MRDDA did not have fully operational databases of all incident reports, neither we nor these agencies could easily determine the extent of this problem.

We also believe it is difficult if not impossible for MRDDA manages to gauge the extent and timeliness of corrective actions taken on behalf of customers because a comprehensive tracking system does not exist. During our review of MRDDA records, we found it necessary to ask about the status of a reported incident beyond the case manager's initial disposition. For example, we noted instances in which a case manager was directed to take additional action on a reported incident by a supervisor. The only way to determine whether this action was completed was to ask MRDDA staff. Even more difficult and

time consuming was determining whether an incident was being investigated by another agency. The MRDDA had a record of incident reports sent to DHS/OIC but did not maintain information on the status of DHS/OIC investigations and had little information on investigations being conducted by other agencies.

Responsibility for receiving and tracking incident reports was again reassigned in January 2000. At that time, MRDDA staff began logging incidents in a notebook, while continuing to work with a contractor to develop an automated tracking system.

We also understand that MRDDA staff are maintaining a manual log of referrals of incident reports made to other agencies, as well as tracking the internal distribution within MRDDA, and plan to request feedback on actions taken within a specified time. This process could provide MRDDA with important information, however, MRDDA must make a resource commitment to ensure that it works and get a commitment from other agencies to support the effort.

DOH/LRA. The Health Facilities Division was not entering all incident reports received in its tracking system; it only logged incidents it investigated. During our audit, the Division was implementing a new tracking system and could not produce a listing of incidents from the system being replaced for the time period we were reviewing, and instead, provided a handwritten listing. The Human Services Facilities Division is also manually logging incidents while it develops a new tracking system.

DHS/OIC. The OIC had a 3 year database of incident reports but, based on our sample, its database was not complete. Seven of the 65 incidents sampled, which we selected from MRDDA records, had not been received by OIC. We could not determine whether MRDDA had failed to send the report to the OIC or whether OIC had not logged the report. The current OIC tracking system also does not capture information on the status of recommendations made as a result of its investigations.

District agencies need functional databases not only to manage day-to-day operations but to effectively identify systemic problems and take meaningful corrective actions. For example, after noting several incidents involving transportation services and day programs, we asked if MRDDA maintained records of incidents involving these providers. The MRDDA's response was that it had not maintained such information but had started to track these incidents. Functional databases would enable agencies to prepare periodic management reports on trends which should be evaluated and disseminated, such as identifying: (1) misuse of restraints; (2) facilities with a high rate of runaways; (3) nonreporting facilities; and (4) customers and facilities with repeat incidents. Of the District agencies reviewed, the DHS, OIC had the most complete database of incident reports but had not analyzed incident patterns. Other agencies did not have sufficient information to do analyses.

Recommendations. We recommend that:

1. District agencies make implementation of automated tracking systems a priority and ensure that incidents are tracked through corrective action.

2. Based on our experience in analyzing where incidents occurred, the incident report and database record should include: (1) the name and address of the customer's residential facility at the time of the incident, as well as similar information if the location of the incident is different, and (2) information on the care staff in facility at the time of the incident or, in the case of larger facilities, persons in proximity to the incident, even if these persons were not involved in the incident or identified as a witness.

3. District agencies implement controls to ensure that all incident data is entered completely and correctly. We would also recommend that these agencies share listings of reported incidents as a way of determining whether their records are complete.

4. The MRDDA ensure that incidents are tracked through corrective action taken by its case managers and investigative agency(ies).

5. District agencies do frequency and trend analysis of incidents to identify systemic problems with residential or other service providers.

Investigating Incidents

Incident investigation in the District is fragmented. Agencies that received and investigated incidents we reviewed included: DHS/OIC; DHS, Adult Protective Services (APS); DOH/LRA; and DOH, Medicaid Assistance Administration (MAA). The Metropolitan Police Department was also involved in some incidents such as allegations of sexual abuse.

We found that many reported incidents were not investigated by any agency. As detailed in the chart below, of the 65 incidents in our sample, 14 were investigated by DHS/OIC, DOH/LRA or DOH/MAA and a report issued. Additionally, the DHS/APS looked into 5 incidents involving 3 customers.

Type of Incident	Sampled Incidents	No. of Incidents Investigations/ Followups	Investigations			APS Followup
			OIC	DOH/LRA	MAA	
Injury or Illness	21	2		1	1	
Potential Abuse/Neglect by Care Staff	16	6	3	2	1	1
Elopement, i.e., customer left facility without supervision	6	1	.			1
Death	5	3	1	2		
Customer-to-Customer Assault	5					
Potential Abuse by Family Member	3	2				2
Restraints	1					
Other	8	4	1	2		1
Total	65	18	5	7	2	5

We also found that some District agencies were simultaneously investigating the same incident. There are 19 investigations or follow-ups noted in the chart above for 18 incidents. The difference is due to 2 agencies investigating the same incident. However, if we considered reviews which stop short of a full field investigation and investigations in progress, the number of multiple investigations would increase to 9 since the District has no process for determining which agency should take the lead in an investigation.

An investigative agency must receive the incident report in a timely manner to conduct an effective investigation. Delays in the receipt of an incident report can impair the investigator's ability to substantiate an alleged abuse and, in some cases, make it impossible to conduct an investigation. The OIC indicated that they had not received 7 of the 65 sampled incidents from MRDDA. We also noted that, based on information OIC provided about the 58 reports received, 16 of the reports were not received within 4 weeks of the date of the incident even though the policy called for OIC to receive the incident report within 24 hours. Some of these delays may have been caused by providers failing to report incidents to MRDDA timely. However, many delays in providing incident reports to OIC were attributable to MRDDA. The MRDDA has made organizational changes to improve the handling of incident reports including transmittal of incident reports to other agencies. Information is not available to readily determine whether the DOH/LRA received incident reports timely because it did not track all incident reports. However, any delays in receipt would not be attributable to MRDDA since DOH/LRA was receiving incident reports directly from providers.

Each agency that receives an incident report makes an independent determination on what level of investigation is needed, whether to issue a report, and determines who receives the report. However, there are no procedures for these agencies to share information. We found the dissemination of investigation results among agencies, such as between the DHS/OIC and DOH/LRA, to be informal and dependent on the working relationships of agency staff. Other

than by DOH/LRA, there was no indication that providers were notified of the outcome of an investigation.

Policies and Procedures

We also found that District agencies did not have adequate, up-to-date policies and procedures, performance standards and other guidance for employees who resolve or investigate incidents. The DOH/LRA division that acts as the survey agency for federally-funded facilities follows investigation and reporting guidelines and time frames in HCFA's *State Operations Manual.* These requirements cover investigations of facilities housing approximately one-half of MRDDA's customers. Otherwise, there is little in the way of policies and procedures or operational guidance for conducting investigations in the District. Each agency generally operated under its own policies and procedures, some of which were undocumented. We would not consider any of the policies and procedures we reviewed or discussed with agency officials as providing sufficient guidance to investigative staff that screen incident reports or conduct investigations. We understand some agencies are developing specific investigative policies and procedures.

The revised incident reporting policy adopted by DOH and DHS at the end of December 1999 specifies that all incidents are to be investigated by either the Metropolitan Police Department, the Office of the Medical Examiner, the D.C. OIG, or other appropriate agency, but the policy lacks detail on how this will be accomplished. For example, the policy statement does not address how the District will ensure that MRDDA forwards all incident reports to one of the designated agencies for investigation in a timely manner, which agency will handle the investigation, what practices will be adopted to ensure that investigations are completed in a timely manner or what steps the District will take to ensure that agencies share information and avoid duplicative investigative efforts. The District will also need a screening process to determine what incidents should be investigated. At the time we completed our field work, we estimated that MRDDA was receiving an average of 50 incident reports a month. We have been told that the number has increased significantly since MRDDA renewed its efforts to ensure that incidents are reported. As a practical matter, it is unlikely, considering available resources, that every incident will receive a full field investigation. Without a centralized screening process in place, several District agencies may commit investigative resources to the same incident, backlogs in investigations may occur, and scarce investigative resources may not be maximized.

Providers may do an in-depth review of the circumstances surrounding an incident and submit a report on their findings as part of their internal policies. Additionally, Federal regulations require ICFs/MR to perform and submit a follow up report of an incident if all the details surrounding the incident are not available at the time the initial report is filed. In certain instances, these follow up reports may provide sufficient information to the investigative agency to close a case. In other instances, a complete, independent investigation would be warranted. Appropriate use of fact-finding or "investigative" reports from providers should be addressed in developing investigative guidelines to ensure that significant backlogs of uninvestigated incidents doesn't develop and overshadow the need for an immediate investigation of a serious occurrence.

Recommendations. We recommend that:

1. The District ensure that there is a timely investigation of serious incidents. To facilitate the timely investigation of incidents, the DHS and DOH should promptly resolve delays in transmittal of incident reports and completion of investigations. Investigative agencies receiving incident reports from MRDDA should provide immediate feedback to senior DHS management when there are significant delays in the transmittal of an incident report so that the issue can be promptly resolved. The MRDDA should also provide immediate feedback to senior management at the investigative agencies when there are significant delays in completing a requested investigation.

2. District agencies coordinate their actions on reported incidents to avoid duplicate investigations.

3. The DHS and DOH develop performance standards and guidelines for investigations. Investigative guidelines should cover time frames for initiating an investigation, use of "fact finding" reports prepared by facilities, and the extent of independent fact gathering.

4. District agencies routinely disseminate the results of their reviews and investigations, including investigations where deficiencies were not found, to MRDDA and other investigative agencies. Providers should also be advised of the outcome of an investigation.

5. Employees investigating incidents be provided relevant training in how to effectively communicate with MRDDA customers and witnesses.

Additional Safeguards

Mortality Review

An independent review of all deaths is one of the practices that we identified as a primary safeguard from our work in other States. The District needs a mortality review process to identify systemic problems, such as the failure to initiate timely medical interventions, that can adversely affect the future health and well-being of MRDDA customers. The mortality review group should receive reports of all deaths and screen these reports to identify unexplained or unexpected deaths or deaths which suggest possible deficiencies in care or medical treatment for further investigation.

We were provided a March 2000 order, signed by the District's Mayor, directing that a fatality review committee be established within 60 days. Details of the committee's operating policies and procedures are to be developed within this time frame.

Recommendation: We recommend that the District's fatality review process be started as soon as possible and that District agencies are made aware of their responsibilities for providing requested information.

Protecting MRDDA Customers during Investigations

Protecting a MRDDA customer during an investigation of an allegation of abuse, neglect or mistreatment by care staff is essential and should be rigorously monitored by the District.

About half of MRDDA's customers reside in facilities that are subject to HCFA's conditions of participation. These facilities' operators are required to develop and implement policies and procedures to safeguard the customer during an investigation involving potential abuse or neglect by care staff, e.g. by placing involved care staff on administrative leave or transferring the staff to another facility to avoid contact with the customer.

There is no District requirement for a similar safeguard for persons residing in facilities not subject to the Federal requirements, attending day programs, or receiving independent transportation services, although some of these providers may voluntarily take such action.

Recommendations. We recommend that the District require that:

1. Facilities not subject to Federal regulations have safeguards in place to protect the MRDDA customer during an investigation of an incident.

2. Providers detail actions taken to safeguard the customer as part of the incident report and, if not reported, that case managers immediately follow up.

3. As part of an incident investigation, District agencies ensure that the provider is taking appropriate action to protect the customer and witnesses.

Restraints

The District allows the use of physical, mechanical or chemical restraint if the practice is part of an approved behavior management plan for the customer to control unacceptable behaviors. We were able to identify few reported instances of the use of behavior management interventions by providers, including the use of restraints and time-out episodes, although the case managers we talked to indicated that as many as 30 percent of their assigned customers had behavior management plans in place. Specifically, of the 560 incidents logged by MRDDA from January - October 1999, only 4 incident descriptions referred to the use of physical restraints. However, during the period covered by our review, MRDDA did not specifically require facilities to report the use of restraints. As such, neither we nor MRDDA could determine from incident reports the extent to which facilities used restraints.

In December 1999, the DOH and DHS issued a revised incident reporting policy that made the use of a restraint a reportable incident. However, we believe MRDDA needs to provide more

specific reporting guidance to effectively implement this requirement by clearly defining what is meant by a physical, mechanical or chemical restraint.

We also considered what requirements the District has established for care staff that may implement a behavior management plan. Regular, relevant training on the use of restraints by care staff is essential to prevent unintended injury to the MRDDA customer and also to reduce the possibility of injury to the care staff. We determined that the District does not have specific training requirements for care staff who may implement a behavior management plan. The applicable D.C. municipal regulation states that "restraints, control and behavior modification programs ... shall be conducted only under the direct supervision of a qualified person ...having direct, supervised experience and training in the method employed." However, the regulation is silent on the training required of care staff who may actually apply the restraint or implement a behavior management program. Through discussions with MRDDA staff, we determined that the amount and type of care staff training is left to the judgement of the provider.

Recommendations. We recommend that:

1. The MRDDA provide more specific direction to providers on restraint reporting to ensure that case managers can readily determine that the use of the restraint was in accordance with District law and other requirements. For example, if a mechanical restraint is used, the provider should include in the incident report information on who ordered the use of the restraint, the duration of the restraint and who made the required checks while the customer was restrained.

2. The District establish, as part of its municipal regulations, specific training requirements, both hours and content, for all care staff that implement behavior management plans and follow up to ensure that the providers are providing regular and relevant training to care staff in how to use, when to use, when to avoid, and how to de-escalate occurrences which may lead to restraint. We would also recommend that the District require new care staff to complete the required training before providing direct care to MRDDA customers with behavior management plans.

Nationwide Criminal Background Checks of Care Staff and an Abuse Registry

The District's City Council passed a law requiring facilities to arrange for nationwide criminal background checks of all care staff through the D.C. Metropolitan Police, however, the implementing regulation has not been finalized.

At least 16 of the 65 incidents we reviewed involved potential abuse or neglect by care staff. Most of these instances involved physical abuse or rough handling. Following is a summary of actions taken in response to the 16 reported incidents. In nine cases, providers conducted internal investigations and terminated the employee(s) or the employee resigned. Two incidents resulted in providers being removed from the program. In the remaining five cases, the alleged abuse was not substantiated or was handled through an administrative action by the provider, such as in-service training of care staff.

Three of the 16 incidents were also referred to the D.C. Metropolitan Police. One of the referrals resulted in an arrest of two care workers. However, in most instances, the abuse or neglect was not legally substantiated and there will be no public record of the incident. Without a process for tracking care staff determined to have been involved in committing abuse, such as an abuse registry, there is no assurance that staff terminated from a facility for suspected abuse or neglect will not turn up in another facility.

Recommendations. We recommend that:

1. The District finalize the requirement for a nationwide criminal background check of care staff as soon as possible and monitor providers to ensure that these checks are made.

2. The District consider implementing an abuse registry to provide an additional safeguard to MRDDA customers and other institutionalized District residents.

<u>Independent Party to Assist in Filing Complaints</u>

Many MRDDA customers reside in smaller facilities that do not have a human rights officer to assist in filing complaints, explain customer's rights, or intervene on behalf of the customer when an incident occurs. District Law 2-137 requires that a court-appointed mental retardation advocate be available to a MRDDA customer and that the advocate receive notification of incidents and the use of restraints. While this advocate could act as a human rights officer for the customer, the DOJ has reported that advocates are not available for many MRDDA customers. We understand that the DOJ and others are working to ensure that advocates are appointed.

Facility-established human rights committees are available to customers but these committees do not operate completely independent of the provider. There is also a MRDDA human rights committee comprised of providers, a customer, an attorney, the court monitor, and MRDDA staff to ensure that customers' rights are protected. Specifically, the MRDDA human rights committee bylaws state that the committee "is to review human rights issues, including allegations of abuse, neglect or improper use of restraints." However, the Committee has not been routinely reviewing reported incidents.

Recommendations. We recommend that:

1. Until advocates are available, the MRDDA Human Rights Committee should review reported incidents. While it may not be practical for the Committee to review each incident report, at a minimum the Committee should be provided a listing of all incidents received. We found that scanning listings of incidents allowed us to gain an understanding of the types and frequency of certain occurrences and believe that a similar review by Committee members would not be overly burdensome.

   The Committee should also be kept informed of the outcome of incident investigations and should have access to someone in the Mayor's immediate office to voice concerns about uninvestigated incidents or untimely investigations.

2. The MRDDA also develop summary information that would assist the Committee in identifying systemic problems. For example, summary information on the number of incidents by provider, types of incidents reported, and customers with multiple incidents would be useful information to the Committee. We recognize that this type of information is more practically produced from an automated database and MRDDA may not be able to immediately act on this recommendation. However, as part of the automated tracking system development process, MRDDA should work with the Committee to develop standard reports.

3. The MRDDA make a concerted effort to ensure that customers, family members and guardians are aware of their right to file a complaint directly with the hotline which receives reports of incidents or through the District's protection and advocacy group.

Notification of Family Members, Guardians, and Attorneys

District Law 2-137, Section 6-1970(e) states: "Alleged instances of mistreatment, neglect or abuse of any resident shall be reported immediately to the [facility] Director and the [facility] Director shall inform the resident's counsel, parent or guardian." Section 6-1970(f) includes a similar notification requirement whenever restraints are used.

During our review of incident reports, we made an effort to determine whether family members, guardians or attorneys were notified when an incident occurred. Some providers documented that the family, guardian and/or attorney had been notified on the incident report form. A few case manager disposition forms documented that the customer's family or legal representative had been contacted or were aware of the incident. However, in 36 of the 65 incidents reviewed, we could not determine whether the provider or MRDDA staff had contacted the customer's family, guardian or attorney. It is possible that the appropriate notification was made and documented in files the provider maintained at the facility which we did not review.

Recommendation. We recommend that MRDDA ensure that providers make the required notifications to parents, guardians, and/or attorneys and complete the notification section of the revised incident report and follow up if the information is missing. It is likely that MRDDA will need to issue guidance to providers on what incidents require notification. In some instances, we would suggest that MRDDA follow up to confirm that the notifications were made. The MRDDA should also provide the family, guardian and/or attorney with the results of any investigation of the incident regardless of outcome.

Mandatory Reporters

We read approximately 250 incident reports received by MRDDA during the first half of CY 1999. Few of these incidents were reported by someone other than provider staff. Many of the incident reports concerned an injury to the customer that required medical treatment. Frequently, the treatment was at a hospital emergency room. In the District, health professionals are required to report suspected cases of abuse and neglect to the child or adult protective agency.

Recommendation. Since most of MRDDA's customers are adults, we recommend that MRDDA and the APS work with health professionals providing services to MRDDA customers or who may come into contact with MRDDA customers to ensure that these outside parties are alert to potential abuse and neglect and adhere to mandatory reporting laws.

Other Recommendations

Centralized Incident Reporting and Tracking

The District needs to look at how it handles incidents. There is no single District agency that has responsibility for receiving, tracking, and investigating all allegations of abuse or neglect of persons with disabilities. Also, the District does not have a central database of actions taken on reported incidents. Each agency that received an incident report maintained its own tracking system and is continuing this practice in the development of new systems. We found it difficult and time consuming to follow the 65 sampled incidents from agency to agency to determine if an agency had received an incident report, and, if so, what actions it had taken. We believe that these stand-alone systems have contributed to the lack of coordination among District agencies and resulted in duplication of effort.

Several States we reviewed have established an independent group or agency to receive and resolve incident reports. These States described benefits in having a separate group control the tracking and resolution of incident reports as including: (1) independent oversight of reported incidents, (2) centralized monitoring of the status of ongoing investigations and investigative findings, and (3) the ability to produce comprehensive statistical and management reports. A central group can also coordinate investigative efforts to ensure that the most appropriate agency takes the lead in the investigation and avoid duplicating investigative efforts. As an example, the central group can determine when development of a criminal case is the likely outcome so that the incident is referred immediately to a law enforcement agency to ensure that an administrative investigation does not compromise the evidence necessary for prosecution.

Recommendation. We recommend that the District consider establishing a central reporting point for providers to report incidents and the public to report complaints. This central point could: (1) maintain the database of incidents from receipt through final action; (2) screen incidents and do a risk assessment to determine the most appropriate agency to conduct an investigation; (3) handle distribution of incident reports; (4) follow up on the status and outcome of investigations and recommended corrective actions; and (5) do profiling of reported incidents to identify systemic problems.

Independent Investigative Agency

The OIC, which has been the primary agency for investigating reported incidents involving MRDDA customers, is part of the same Department as MRDDA. Generally, OIC reports are addressed to an official within DHS, usually the MRDDA Administrator; however, certain high profile reports have been addressed to the Director, DHS. Ideally an investigative agency should report to an independent agency or group or periodically report on its activities to a high-level official outside its assigned Department.

Recommendation. We recommend that the OIC provide a periodic report to a senior District official located outside DHS on its activities, including a brief summary of the status of major ongoing investigations and a summary of major findings and recommended corrective actions made to other agencies. Ideally, other investigative agencies would provide similar reports to give a comprehensive picture of investigative efforts.

Case Files

Working with our initial sample of 42 incident reports, we requested the customer's file expecting to review the incident report and case manager disposition form related to the sampled incidents, similar information on previously reported incidents, and case manager notes documenting facility visits. More often than not, little information related to the sampled incident was in the file. We found it necessary to request information on actions taken on 33 of the 42 incident reports reviewed to get a complete picture of what actions MRDDA had taken in response to the reported incident. Also, none of the files we reviewed contained copies of investigation reports completed by other agencies.

When documentation was not in the file, we requested that the information be located and provided. While this caused delays in completing the audit and used MRDDA staff time, the information was usually provided. However, problems arose when there was a change in case managers. In some instances the newly assigned case manager could not locate information or documentation that was referred to in the previous case manager's notes.

Recommendation_ We recommend that MRDDA maintain records documenting the complete history of an incident from initial report through completed resolution or investigation. Availability of this type of information is important for ongoing program management purposes and will be necessary for follow up reviews to determine that incidents are being properly handled.

DISTRICT OF COLUMBIA'S COMMENTS AND OIG RESPONSE

In its August 10, 2000, response to our draft report, the District generally concurred with our recommendations and provided detailed comments on actions taken or planned to implement needed safeguards. Based on the information provided by the District, we made minor changes to this report to clarify District processes. These changes did not affect the reported findings or recommendations. Comments from the District to our draft report are included in their entirety in Appendix A. With agreement from District officials, we have not reproduced the draft policy referenced in the District's comments. When finalized, the referenced policy will be available directly from the District.

We appreciate the District's thorough response to our report. We recognize that, to make substantive changes, District agencies must not only adopt new policies and procedures but

effectively implement them. We are providing a copy of this report to the D.C. OIG to assist them in conducting a follow-up audit.

****

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Department of Health and Human Services, Office of Inspector General, Office of Audit Services reports are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (See 45 CFR, Part 5.)

APPENDIX

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

DIRECTOR

IG	✓
EAIG	✓
PDIG	✓
DIG-AS	✓
DIG-EI	
DIG-OI	
DIG-MP	
OCIG	✓
ExecSec	✓
Date Sent	8-11

RECEIVED
2000 AUG 11 AM 11:45
OFFICE OF INSPECTOR GENERAL

AUG 10 2000

June Gibbs Brown
Inspector General
Office of the Inspector General
Department of Health and Human Services

Ref: A-12-99-00008

Dear Ms. Gibbs Brown:

On behalf of Mayor Anthony Williams, I am forwarding a copy of the District of Columbia's response to the Draft Report "Safeguarding District of Columbia Residents who have Mental Retardation or other Developmental Disabilities: Responding to Reported Allegations of Abuse or Neglect", dated June 15, 2000.

In responding to the Draft Report, the District of Columbia has chosen to: (1) identify the relevant sections of the Report; (2) restate the **"recommendations"** made by your office; then (3) add the District's **"response"** following the recommendation. You will note that our newly revised Incident Management System is designed in such a manner that it addresses most of your recommendations, wherein recommended procedures and standards are either underway or close to implementation.

The District of Columbia expresses its appreciation for the work done by the staff of the U.S. Department of Health and Human Services, Office of Inspector General (DHHS/OIG) in conducting the audit and preparing the report on the District's ability to safeguard residents with mental retardation or other developmental disabilities. The administrators at the Department of Human Services/Mental Retardation and Developmental Disabilities Administration (DHS/MRDDA), the Department of Health (DOH), and all other relevant agencies will continue to use the report to assist in improving the quality of services provided to District residents with mental retarded and/or developmental disabilities.

Should you have questions please contact me at (202) 727-8001, or Ms. Essie Page, Acting Administrator, MRDDA, at (202) 673-7657.

Carolyn N. Graham
Interim Director

Enclosure

P.O. Box 54047, 2700 Martin Luther King Jr. Avenue, S.E., Washington, D.C. 20032-0247 (202) 279-6002

The District of Columbia's Response

To The U.S. Department of Health and Human Services (DHHS) Draft Report Entitled:

"Safeguarding District of Columbia Residents who have Mental Retardation or other Developmental Disabilities: Responding to Reported Allegations of Abuse or Neglect"

August 10, 2000

Introduction

The District of Columbia herein responds to the Draft Report "Safeguarding District of Columbia Residents who have Mental Retardation or other Developmental Disabilities: Responding to Reported Allegations of Abuse or Neglect", dated June 15, 2000. This report was prepared by the U.S. Department of Health and Human Services, Office of Inspector General (DHHS/OIG), in response to a request from the former Director of the D.C. Department of Human Services (DHS) and the U.S. Department of Health and Human Services' Administration on Developmental Disabilities (DHHS/ADD).

In responding to the Draft Report, the District of Columbia has chosen to: (1) identify the relevant sections of the Report; (2) restate the **"recommendations"** made by DHHS/OIG; then (3) add the District's **"response"** following the recommendation.

The District of Columbia expresses its appreciation for the work done by the staff of the DHHS/OIG in conducting the audit and preparing the report on the District's ability to safeguard residents with mental retardation or other developmental disabilities. The administrators at the Department of Human Services/Mental Retardation and Developmental Disabilities Administration (DHS/MRDDA), the Department of Health (DOH), and all other relevant agencies are using the report to assist in improving the quality of services provided to District residents with mental retarded and/or developmental disabilities.

DISTRICT OF COLUMBIA'S RESPONSE TO RECOMMENDATIONS CONTAINED IN THE DHHS AUDIT REPORT

REPORTING OF INCIDENTS: Pages 10 and 11 of Draft Report Recommendations

1. The DHS and DOH review current incident reporting requirements in policy statements, municipal regulations and contracts, and where necessary, make appropriate revisions to ensure that providers receive consistent guidelines.

RESPONSE: The District is currently preparing to implement a newly revised Incident Management policy and procedure, jointly issued by DHS and DOH, that has been further updated from the December 1999 policies. This newly revised policy reflects comprehensive set of standards for identifying incidents, reporting of those incidents, investigation of serious reportable incidents per the policy, and quality improvement functions for both providers and District government agencies. See the attached policy for further reference.

2. Incident reporting requirements be added to municipal regulations covering all providers, including day programs and transportation service providers.

RESPONSE: The above referenced policy has been expanded to include this scope of coverage. Existing rules, adopted in March 2000, must be broadened. Therefore, the District is moving to have the newly revised policy adopted formally through the District's rule-making process. Language has also been added to the policy clearly stating that any employee, sub-contractor, consultant, interns and volunteers of those organizations are required to abide by policy requirements.

3. The DHS and DOH develop standard definitions for terms used in used in incident reporting guidance.

RESPONSE: The newly revised Incident Management policy attempts to further delineate definitions using terms that provide better opportunity to "measure" observations made by individuals who are reporting incidents. Many of these definitions are based on regulatory language used by other government jurisdictions that have recently undergone revisions to incident reporting policies. These revised definitions have been generally accepted by Department of Justice (DOJ), Health Care Financing Administration (HCFA), and the protection and advocacy systems throughout the country.

4. The DHS and DOH ensure that agency and provider staff receive periodic training in incident reporting.

RESPONSE: Training was initiated in February regarding the policy drafted in December, 1999. This was a mandatory training focused on agency administrators and direct care staff. The District intends to design and provide a comprehensive training process with the implementation of the newly revised policy during the Fall of 2000 (see attached proposed

Training Plan). This training will be directed at provider agency Board of Directors, administrators, direct care and clinical staff, agency support staff, District employees, and most importantly, customers of the MRDDA system. It will involve multiple levels of training pertaining to the:

1. revised policy on Incident Management;
2. reporting responsibilities and protection issues for customers and employees;
3. organizational responsibilities for managing of incidents involving harm, or potential harm to customers, including quality assurance standards for reporting, monitoring, and investigation of serious incidents.
4. technical training on investigative methodology to identified provider agency investigators/Incident Management Coordinators and District personnel who conduct incident investigations;
5. technical training on reconciliation of evidence for investigators, agency administrators and Incident Management Committee/Human Rights committee members.

This plan will also address the necessary time frames for implementing the delivery of training related to incident management issues. It will also address the proposed structure for maintaining training opportunities on an ongoing basis. The plan will also address what will be the District's responsibility for providing training supports in defined areas (i.e., basic incident investigation training) versus training resources (i.e., curriculum offerings) that would be designed and provided to provider agencies to be incorporated in an internal agency training/education program.

5. The DHS and DOH determine whether providers adhere to the recently revised incident reporting requirements during periodic site reviews and be more diligent in identifying unreported incidents. The MRDDA should direct its case managers to notify DOH of instances of noncompliance so civil fines and penalties can be assessed where appropriate. We also recommend that MRDDA staff pay special attention to incident reporting during visits to nursing homes and out-of-State facilities.

RESPONSE: The MRDDA is in the process of establishing an Incident Management Unit. The responsibility of staff in this unit will be to:

a. monitor provider compliance with the revised Incident Management policy;
b. provide technical assistance to providers in relation to incident management/quality assurance responsibilities;
c. monitor serious incident investigation activities conducted by providers;
d. assess the need for a serious incident investigation as reports of incidents are generated to MRDDA. Determine whether appropriate District authorities have been notified and/or are beginning to undertake investigations (i.e. MPD, U.S. Attorney's Office, Department of Health/Health Regulations Administration, DHS/Adult Protective Services and Child Protective Services; DHS/Office of Investigations and Compliance;

e. conduct serious incident investigations as necessary and as a part of the District's responsibility to independently investigate serious incident reports including abuse/neglect allegations, serious injuries, theft of client funds, and deaths;
f. monitor the status of parallel investigations that might occur;
g. ensure incident report data is entered into the MRDDA incident management database;
h. generate regular reports (per policy) of incident trending information.

Case Management staff are required to be notified immediately by the provider agencies of serious incidents that occur (per the attached Incident Management policy). They will also be given regular trend reports of all reportable incidents relating to the consumers assigned to their caseloads. Incident Management training for Case Managers will focus on the on-going monitoring of services/needs of consumers (when they conduct visits with the people they serve), which also includes reviewing provider records, etc.

As to out-of-state facilities and nursing homes, quality assurance efforts in monitoring sites is being strengthened at the present time. Although the District of Columbia does not have any legal authority over nursing homes and facilities in other states, the District is working to coordinate its quality assurance efforts with the appropriate state agency in other jurisdictions.

6. The MRDDA develop performance standards for the disposition of incidents by its case managers. The MRDDA should provide case managers with guidance on what actions are to be taken in response to a reported incident and monitor case manager performance with these guidelines. We would suggest that case manager supervisors make unannounced follow-up visits at facilities with major incidents or numerous incidents to ensure that case manager disposition guidelines are adequate and are being followed.

RESPONSE: Case Managers are not responsible for implementation of the disposition of incidents. This is the primary responsibility of the provider where the incident occurred. The role of Case Managers in the incident management process is to: (1) monitor incidents that occur involving individuals on a caseload; (2) ensure that the customer is receiving adequate protection and supports during an investigation; (3) ensure that corrective actions/recommendations are in fact being implemented once an investigation has been brought to conclusion. The District is currently reviewing the role/function of case management services provided by MRDDA. As a part of this review, performance standards related to case management functions in regards to incident management issues will be addressed.

TRACKING INCIDENTS: Pages 13 and 14 of Draft Report Recommendations

1. District agencies make implementation of automated tracking systems a priority and ensure that incidents are tracked through corrective action.

RESPONSE: The District government is developing and refining a new MRDDA Customer Information System (MCIS), which is on line and includes a database for incident processing. The incident processing system is in its beta stage of implementation testing and reflects a core

tracking database of unusual incident reports (UIRs) from November 1999 to the present. Of significance is the planned development of an integrated enterprise system that would link the MCIS to several key agencies, including the DHS Office of Investigations and Compliance (OIC), the Department of Health, to include the Health Regulations Administration and the Medical Assistance Administration. These linkages are critical in the management of serious reportable incidents, coordination of investigations, corrective action planning and implementation, and ongoing monitoring.

2. Based on our experience in analyzing where incidents occurred, the incident report and database record should include: (1) the name and address of the customer's residential facility at the time of the incident, as well as similar information if the location of the incident is different, and (2) information on the care staff in the facility at the time of the incident or, in the case of larger facilities, persons in proximity to the incident, even if these persons were not involved in the incident or identified as a witness.

RESPONSE: The revised Incident Report form will include data fields for the name/address of the facility/environment where the incident occurred, and the name/address of the customer's current residential environment. There are also data fields to indicate names of individuals that were in proximity to the incident when it occurred or names of care staff on duty at the time the incident was being witnessed or discovered.

In addition, data fields are included for both the "primary location" (residence, day program, during transportation, etc.) and "secondary location"(bedroom, bathroom, kitchen, etc.) for documenting where the incident occurred. This allows for trending of patterns of harm to a more comprehensive level, i.e., a large number of incidents that have occurred in the bathroom of a specific group home which may raise question as to environmental concerns, such as composition of flooring materials, that may have contributed to people slipping and sustaining injury.

3. District agencies implement controls to ensure that all incident data is entered completely and correctly. We would also recommend that these agencies share listings of reports incidents as a way of determining whether their records are complete.

RESPONSE: As part of the protocols for quality assurance needs for the MRDDA incident database, a quarterly audit will be conducted matching original incident reports to the data entered into the MCIS system. A formal sampling protocol will be developed for this purpose. The MRDDA Incident Management Unit will also implement similar protocols for auditing the incident reporting databases that provider agencies will create as part of the revised Incident Management policy.

4. The MRDDA ensure that incidents are tracked through corrective action taken by it case managers and investigative agency(ies).

RESPONSE: The incident report form for provider agencies includes sections for documentation of corrective actions taken by staff in response to the reportable incident. Provider agencies will also be given a format for preparing a **Serious Incident Investigation**

Report which includes a section for recommended corrective actions by the agency's Incident Management Review process, as well as documentation of implemented corrective actions. The Investigative Report is to be submitted to the MRDDA Incident Management Unit for review and tracking.

5. District agencies do frequency and trend analysis of incidents to identify systemic problems with residential or other service providers.

RESPONSE: Per the revised Incident Management Policy, provider agencies are required to submit to the MRDDA Incident Management Unit the trend analysis information of all reportable/serious reportable incidents. Trend reports are to be submitted on a monthly basis (no later than the 5th business day following the end of the month. The trend report is to include not only the current monthly data as outlined in the policy, but a "year to date" analysis as well.

INVESTIGATING INCIDENTS - Pages 16 and 17 of the Draft Report Recommendations

1. The District ensure that there is a timely investigation of serious incidents. To facilitate the timely investigation of incidents, the DHS and DOH should promptly resolve delays in transmittal of incident reports and completion of investigations. Investigative agencies receiving incident reports from MRDDA should provide immediate feedback to senior DHS management when there are significant delays in the transmittal of an incident report so that the issue can be promptly resolved. The MRDDA should also provide immediate feedback to senior management at the investigative agencies when there are significant delays in completing a requested investigation.

RESPONSE: The attached Incident Management policy provides clear standards on receiving incident reports, making determinations to initiate and complete investigations, both by the providers as well as District government agencies (including the MRDDA Incident Management Unit). As a part of the quality assurance process this will be an area that will be monitored for compliance on a regular basis and is included as a part of the incident management database. When there are delays with providers completing the investigation as required by policy, protocol has been delineated for formally communicating a request for an extension of the deadline. These requests will be included as a part of the investigation file.

2. District agencies coordinate their actions on reported incidents to avoid duplicate investigations.

RESPONSE: One of the primary functions of the MRDDA Incident Management Unit will be to coordinate and monitor investigation activities that might need to occur between various District government agencies. However, independent investigations undertaken by other agencies (e.g., criminal investigations by the FBI, U.S. Attorney's Office or DHS/OIC) cannot be subordinated to any civil/administrative investigation that may occur. The District government agencies will work to the best degree possible to coordinate any criminal, civil or administrative investigations that are undertaken in response to incidents involving persons who are mentally retarded or developmentally disabled.

3. The DHS and DOH develop performance standards and guidelines for investigations. Investigative guidelines should cover time frames for initiating an investigation, use of "fact finding" reports prepared by facilities, and the extent of independent fact gathering.

RESPONSE: The attached **Incident Management Policy** and draft of the **Procedures for the MRDDA Incident Management Unit** includes defined protocols for investigative procedures. It is the intent of the District to ensure that incident management systems include defined performance standards for investigative procedures that will apply to both contract providers as well as District employees performing those functions. An assessment tool will be refined over the next six months that will be used for this purpose and made available to provider agencies as a part of this quality assurance process.

4. District agencies routinely disseminate the results of their reviews and investigations, including investigations where deficiencies were not found, to MRDDA and other investigative agencies. Providers should also be advised of the outcome of an investigation.

RESPONSE: The attached draft of **Procedures for the MRDDA Incident Management Unit** includes the requirement that MRDDA/District investigative findings and recommendations be communicated back to providers within seven (7) days of the report being finalized. See attached draft of the "Procedures" for further detail.

5. Employees investigating incidents be provided relevant training in how to effectively communicate with MRDDA customers and witnesses.

RESPONSE: Included in the upcoming technical training on investigative process will be modules associated with specialized issues on communication with victims and witnesses who may be mentally retarded or developmentally disabled with communication and/or cognition impairments. Also included will be training on determining the competency of persons who are mentally retarded or developmentally disabled to participate in an investigation.

MORTALITY REVIEW: Page 17 of the Draft Report Recommendations

1. We recommend that the District's fatality review process be started as soon as possible and that the District agencies are made aware of their responsibilities for providing requested information.

RESPONSE: Through issuance of a Mayor's Order, dated May 30, 2000, the Mayor established the District of Columbia Serious Incident and Fatality Review Committee. The Committee was appointed on May 31, 2000. The Committee is responsible for examining serious incidents as well as events and circumstances surrounding the deaths of District wards or residents in the District with mental retardation, developmental disabilities, or other disabling conditions. The Mayor's Order identifies key District agencies that are to participate on the Committee and defines their responsibilities. At the present time, there is a review underway in which protocols are being established. This Committee is set to begin its work in the month of August 2000.

PROTECTING MRDDA CUSTOMERS DURING AN INVESTIGATION: Page 18 of the Draft Report Recommendations

1. Facilities not subject to Federal regulation have safeguards in place to protect the MRDDA customer during an investigation of an incident.

RESPONSE: The attached Incident Management policy applies to all agencies receiving funds from the District of Columbia government, regardless of source (federal or local appropriations) and includes those on contract as well as under Provider Agreement. There are standards in the policy that require providers to ensure that safeguards, including protecting consumers from retaliatory actions, are in place.

2. Providers detail actions taken to safeguard the customer as part of the incident report and, if not reported, that case managers immediately follow up.

RESPONSE: The revised incident report form includes several sections where various employees and managers document actions taken in response to the incident. These actions are to include documentation of safeguards that providers are putting in place for the customer. Training on the incident management policy and reporting of incidents will include these responsibilities as well.

3. As part of an incident investigation, District agencies ensure that the provider is taking appropriate action to protect the customer and witnesses.

RESPONSE: As previously state, the Incident Management Policy requires providers to ensure that safeguards, including protecting customers from retaliatory actions, are in place.

RESTRAINTS - Page 19 of the Draft Report Recommendations

1. The MRDDA provide more specific direction to providers on restraint reporting to ensure that case managers can readily determine that the use of the restraint was in accordance with District law and other requirements. For example, if a mechanical restraint is used, the provider should include in the incident report information on who ordered the use of the restraint, the duration of the restraint, and who made the required checks while the customer was restrained.

RESPONSE: The attached Incident Management policy addresses the use of restraints (chemical, physical, or mechanical) from the standpoint of incident reporting. This would be in addition to any other clinical documentation of behavior management interventions that might already be in place through a formal behavior management plan.

2. The District establish, as part of its municipal regulations, specific training requirements, both hours and content, for all care staff that implement behavior management plans and follow up to ensure that the providers are providing regular and

relevant training to care staff in how to use, when to use, when to avoid, and how to de-escalate occurrences which may lead to restraint. We would also recommend that the District require new care staff to complete the required training before providing direct care to MRDDA customers with behavior management plans.

RESPONSE: As a part of the District's initiative on creating a comprehensive training program for agency direct care staff, specific training requirements on behavior management will be included as mandatory training. This is to also include a requirement that new employees will be expected to complete this core curriculum prior to hands-on experience with customers.

NATIONWIDE CRIMINAL BACKGROUND CHECK OF CARE STAFF AND ABUSE REGISTRY: **Pages 19 and 20 of the Draft Report Recommendations**

1. The District finalize the requirement for a nationwide criminal background check of care staff as soon as possible and monitor providers to ensure that these checks are made.

RESPONSE: The District of Columbia will review this recommendation to assess whether this requirement can be implemented. The legal scope and complexity of this recommendation is significant.

2. The District consider implementing an abuse registry to provide an additional safeguard to MRDDA customers and other institutionalized District residents.

RESPONSE: The District of Columbia will review this recommendation to assess if the implementation of an abuse registry is feasible. The legal scope and complexity of this recommendation is significant. Careful assessment has to occur if there is to be an abuse registry that contains the names of individuals actually **convicted** through criminal aspects of law, versus a registry of individuals where administrative or civil disciplinary actions have been imposed.

INDEPENDENT PARTY TO ASSIST IN FILING COMPLAINTS: **Page 20 of the Draft Report Recommendations**

1. Until advocates are available, the MRDDA Human Rights Committee should review reported incidents. While it may not be practical for the Committee to review each incident report, at minimum the Committee should be provided a listing of all incidents received. We found that scanning listings of incidents allowed us to gain an understanding of the types and frequency of certain occurrences and believe that a similar review by Committee members would not be overly burdensome. The Committee should also be kept informed of the outcome of incident investigations and should have access to someone in the Mayor's immediate office to voice concerns about uninvestigated incidents or untimely investigations.

RESPONSE: As part of thc creation of the MRDDA Incident Management Unit, review is currently underway in regards to the MRDDA Human Rights Committee and it's role/function in responding to overall quality assurance issues or concerns.

2. The MRDDA also develop summary information that would assist the Committee in identifying systemic problems. For example, summary information on the number of incidents by provider, types of incidents reported, and customers with multiple incidents would be useful information to the Committee. We recognize that this type of information is more practically produced from an automated database and MRDDA may not be able to immediately act on this recommendation. However, as part of the automated tracking system development process, MRDDA should work with the Committee to develop standard reports.

RESPONSE: MRDDA is currently in the process of working with Office of the Chief Technology Officer (OCTO) for District government in further refining the MCIS database on incident reporting. The database will be designed to generate regular trend reports (see attachment - Standard Trend Reports) that will be reviewed per the Incident Management policy. The system will also be designed to automatically provide a "red flag" to patterns of incidents that emerge (i.e., certain number of injuries within a specified time frame), in order to call attention to them beyond the regular trend reports.

3. The MRDDA make a concerted effort to ensure that customers, family members and guardians are aware of their rights to file a complaint directly with the hotline which receives reports of incidents or through the District's protection and advocacy group.

RESPONSE: This will be included as part of a comprehensive training initiative on the revised Incident Management policy that will be specifically geared to customers and their needs. MRDDA has already met with the District's Self-Advocacy association and requested their input and assistance (beginning in September) with the development and implementation of training in this area.

NOTIFICATION OF FAMILY MEMBERS, GUARDIANS, AND ATTORNEYS: Page 21 of the Draft Report Recommendations.

1. We recommend that MRDDA ensure that providers make the required notifications to parents, guardians, and/or attorneys and complete the notification section of the revised incident report and follow up if the information is missing. It is likely that MRDDA will need to issue guidance to providers on what incidents require notification. In some instances, we would suggest that MRDDA follow up to confirm that the notifications were made. The MRDDA should also provide the family, guardian and/or attorney with the results of the investigation of the incident regardless of outcome.

RESPONSE: The attached Incident Management policy addresses this issue by requiring providers to ensure, as a part of their Incident Management program, notification of parents, guardians, and attorneys.

MANDATORY REPORTERS: Page 21 of the Draft Report Recommendations

1. Since most of the MRDDA's customers are adults, we recommend that MRDDA and the APS work with health professionals providing services to MRDDA customers or who may come into contact with MRDDA customers to ensure that these outside parties are alert to potential abuse and neglect and adhere to mandatory reporting laws.

RESPONSE: As a part of the training on implementing the revised DHS/DOH Incident Management Policy, the issues of mandatory reporting will be covered as a part of that curriculum. MRDDA and APS will also need to further assess the issue of mandatory reporting relative to other health professionals in the community and develop a comprehensive plan of public information/training to address this issue.

CENTRALIZED INCIDENT REPORTING AND TRACKING: Page 22 of the Draft Report Recommendations

1. We recommend that the District consider establishing a central reporting point for providers to report incidents and the public to report complaints. This central point could: (1) maintain the database of incidents from receipt through final actions; (2) screen incidents and do a risk assessment to determine the most appropriate agency to conduct an investigation; (3) handle distribution of incident reports; (4) follow up on the status and outcome of investigations and recommended corrective actions; (5) do profiling of reported incidents to identify systemic problems.

RESPONSE: The attached Incident Management policy and "Basic Procedures for the Operation of the DHS/MRDDA Incident Management Unit" reflect the tasks needing to be undertaken in the effective management of incidents involving harm to customers of MRDDA. As a result, this process serves as a central reporting point for government agencies. As outlined and defined by the policy, providers are responsible to report all **serious reportable incidents** to the MRDDA Incident Management Unit. The Unit will also be able to receive reports of **all** incidents (as defined in the policy) or complains/grievances, and as necessary, will ensure communication with the most appropriate parties for intervention/assessment. The Incident Management Unit will have responsibility and the authority to:

1. maintain the incident database;
2. screen all incidents reported to the District per the Incident Management policy and make determinations on investigative functions;
3. ensure incident reports have been distributed as outlined by the policy;
4. monitor the status and outcome of all investigations that might be undertaken by both the provider as well as other District government agencies;
5. provide trend analysis information, including recommendations based on the analysis, to parties designated by the policy on a regular and timely basis.

INDEPENDENT INVESTIGATIVE AGENCY: Page 22 of the Draft Report Recommendations

1. We recommend that the OIC provide a periodic report to senior District officials located outside DHS on its activities, including a brief summary of the status of major ongoing investigations and a summary of major findings and recommended corrective actions made to other agencies. Ideally other investigative agencies would provide similar reports to give a comprehensive picture of investigative efforts.

RESPONSE: The DHS/OIC and the MRDDA Incident Management Unit will provide regular status reports of ongoing investigations and a summary of major findings and recommended corrective actions made to other agencies to both the Mayor, Deputy Mayor for Children, Youth and Family, and to the independent External Monitoring Agency that the District is now in the process of establishing.

CASE FILES: Page 23 of the Draft Report Recommendations

1. We recommend that MRDDA maintain records documenting the complete history of an incident from initial report through completed resolution or investigation. Availability of this type of information is important for ongoing program management purposes and will be necessary for follow up reviews to determine that incidents are being properly handled.

RESPONSE: The MRDDA Incident Management Unit will be developing a comprehensive system of creating and maintaining serious incident reports and investigation files. Incident reports will be maintained chronologically by incident report number, based on a monthly/calendar year system. A parallel system will also be developed that will maintain incident reports by customer name. The third record maintenance system will house investigation files and evidence collected during MRDDA investigations. This system will be available for access, per defined policy, by MRDDA case managers and other employees as necessary.