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**Oversight of Group Homes for the Mentally Retarded
and Developmentally Disabled
Requires Substantial Improvement**

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EXECUTIVE SUMMARY

PURPOSE

Pursuant to Public Law 93-198, Section 455, the District of Columbia Auditor conducted a review of community residential facilities used by the Mental Retardation and Developmental Disabilities Administration (MRDDA). The review focused on activities and matters relevant to the operation, inspection, and oversight of community residential facilities. The Auditor also examined the process used to monitor the quality of care provided to clients in these facilities.

CONCLUSION

The Auditor found that specialized care facilities (adult foster homes) and specialized apartments housing MRDDA clients are not required to be licensed and they are not monitored by the Department of Health's Licensing Regulation Administration (LRA) or the Department of Consumer and Regulatory Affairs' Fire Protection Division and Building and Land Regulation Administration. Additionally, these facilities are not required to have annual fire inspections nor are they monitored for adherence to the District's building code.

The Auditor also found that LRA was not timely conducting annual inspections of intensive care facilities (ICF/MRs) and group homes for mentally retarded persons (GHMRPs). The Auditor also discovered that MRDDA was not conducting physical inspections of facilities housing MRDDA clients outside the District of Columbia. Further, the Auditor found that annual fire inspections were not being conducted in a timely manner nor were they being conducted in accordance with District Law.

In reviewing LRA's and MRDDA's monitoring reports, the Auditor found that the process of monitoring and regulating ICF/MRs and GHMRPs needs substantial improvement. Additionally, this review revealed that the monitoring of care provided to MRDDA clients continues to need substantial improvement. The Auditor's review also revealed that the system for reporting and investigating unusual incidents, complaints and deaths is poorly managed and is also in need of substantial improvements.

MAJOR FINDINGS

1. Specialized home care facilities (adult foster homes) and supervised apartments are not required to be licensed.
2. LRA is not timely conducting annual inspections of ICF/MRs and GHMRPs.
3. LRA is not conducting annual inspections prior to license expiration.
4. Fire inspections are not being conducted in accordance with District law.
5. Annual fire inspections are not being conducted in a timely manner prior to license expiration.
6. The process of monitoring and regulating ICF/MRs and GHMRPs needs substantial improvement.
7. LRA is not providing MRDDA officials with the results of annual inspections and surveys.
8. MRDDA's system of monitoring is placing clients at risk.
9. MRDDA is not monitoring facilities outside the District of Columbia that house the District's mentally retarded and developmentally disabled clients.
10. Criminal background checks of providers' employees are not conducted in accordance with District of Columbia law and regulations.
11. The monitoring of care provided to MRDDA's clients needs improvement.
12. Case management ratios are too high.
13. MRDDA is having difficulty recruiting qualified case managers.
14. MRDDA is not providing continuing education opportunities to case managers.
15. Requirements for reporting all unusual incidents and deaths of MRDDA clients is inadequate.

16. Unusual incidents are not being reported properly.
17. Investigations of unusual incidents, complaints and deaths are inadequate.
18. MRDDA is not adequately managing the investigation of unusual incidents.
19. Department of Human Services' Office of Investigations and Compliance is not investigating unusual incidents in a timely manner.
20. LRA is not adequately conducting investigations of unusual incidents.

RECOMMENDATIONS

1. The Council of the District of Columbia consider requiring that all facilities housing MRDDA clients, including foster homes and apartments, be licensed in order to ensure that they are: 1) regularly inspected; 2) adhering to District of Columbia health and safety regulations; and 3) that facility providers are fulfilling their fiduciary and contractual obligations to ensure the health and safety of MRDDA clients. The licensure requirement would also reveal whether these facilities are adhering to the District's building and fire codes.
2. The Director of DOH provide LRA with sufficient resources to increase staffing levels for facility inspectors thereby facilitating timely, thorough health and environmental inspections prior to license expiration.
3. DCRA should immediately commence conducting annual fire inspections of all ICF/MRs and GHMRPs in accordance with D.C. Law 12-86.
4. The Council of the District of Columbia consider enacting legislation requiring the Fire Marshal of the District of Columbia to conduct annual fire inspections of all facilities housing mentally retarded and developmentally disabled clients served by the District of Columbia.
5. LRA should ensure that annual fire inspections of ICF/MRs and GHMRPs are conducted in a timely manner.

6. The Director of DOH provide sufficient resources to increase the number of LRA facility inspectors in order to timely conduct follow-up visits to deficient ICF/MRs and GHMRPs to validate the abatement of noted deficiencies.
7. LRA must conduct follow-up visits within 30 days of the issuance of a statement of deficiencies to determine whether the cited deficiencies have been abated.
8. MRDDA and LRA must establish a policy of sharing monitoring results. Timely sharing of such information would accelerate the process of deficiency correction in the event that deficiencies are discovered by an MRDDA case manager prior to LRA's annual site visit. Providing MRDDA with LRA monitoring reports could also prevent the possible placement of a client in a facility with unabated deficiencies.
9. Periodic on-site monitoring of out-of-state facilities must be reestablished to ensure the health and safety of clients residing in these facilities.
10. Providers should be required to maintain strict compliance with the criminal background check requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998 or face immediate monetary and other sanctions. Further, LRA must strictly enforce these sanctions.
11. Verification of criminal background checks should be instituted as part of LRA's annual monitoring process.
12. The Director of DHS should increase funding to hire more case managers, thereby reducing the case manager to client ratio and improving MRDDA's effectiveness in serving its clients. Recruitment efforts should include a means to attract persons with the highest level of education and experience possible.
13. The Administrator of MRDDA should require and afford case managers the opportunity for continuing education in order to remain current with state-of-the-art approaches in the treatment and care of persons with mental retardation or developmental disabilities.

14. Standardized policies, procedures and forms should be established for reporting unusual incidents and deaths. Further, the policies and procedures should apply to all individuals and organizations responsible for the care of persons with mental retardation or developmental disabilities. Policies and procedures should also be established to better coordinate the efforts of all agencies responsible for the investigation of unusual incidents, complaints, and deaths of MRDDA clients to ensure thorough and timely investigations.
15. Existing regulations for reporting deaths must be reconciled with internal policies and procedures.
16. A database should be funded and developed for use by all agencies responsible for reporting or investigating unusual incidents to ensure that:
 - a. all unusual incidents are accounted for;
 - b. all unusual incidents, complaints and deaths are investigated in a thorough and timely manner;
 - c. there is a unified system for tracking unusual incidents, complaints, and deaths, by vendor; and
 - d. trend analysis can be conducted to detect unusual trends and patterns by facility and by provider.
17. The Directors of DOH and DHS should adequately fund additional staff for the investigation of unusual incidents, complaints and deaths to ensure thorough and timely investigation of all unusual incidents, complaints, and deaths of MRDDA clients.

PURPOSE

Pursuant to Public Law 93-198, Section 455, the District of Columbia Auditor conducted a review of community residential facilities used by the Mental Retardation and Developmental Disabilities Administration (MRDDA). The review focused on activities and matters relevant to the operation, inspection, and oversight of community residential facilities. The Auditor also examined the process used to monitor the quality of care provided to clients in these facilities.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the review were to determine:

1. the agencies responsible for monitoring community residential facilities;
2. whether the facilities used by MRDDA were properly licensed and inspected;
3. the policy and procedures used to monitor and regulate the operation of these facilities;
4. the policies and procedures used to monitor the quality of care provided to clients in these facilities;
5. the policies and procedures used to report and investigate unusual incidents, complaints, and deaths occurring in these facilities;
6. the address, type, and number of beds in community residential facilities by ward; and
7. the name and address of each facility's owner and operator.

The scope of the review included fiscal years 1998, 1999 and 2000.

In conducting this examination, the Auditor reviewed relevant records of the: Department of Human Services' Mental Retardation and Developmental Disabilities Administration and the Office of Investigations and Compliance (OIC); the Department of Health's Licensing Regulation Administration (LRA); the District of Columbia Fire Marshal's Fire Prevention Bureau; the Department of Consumer and Regulatory Affairs' Building and Land Regulation Administration and Fire Protection Division; and the District of Columbia Long-Term Care Ombudsman Program. Additionally, the Auditor interviewed officials and employees of the aforementioned agencies. The Auditor also reviewed applicable District of Columbia laws and regulations to ascertain the District's

responsibility for ensuring the safety and care of mentally retarded and developmentally disabled persons receiving services through MRDDA.

BACKGROUND

According to information provided to the Auditor, MRDDA's mission is to:

Plan, coordinate, develop, and administer a network of services and supports to persons with mental retardation or other developmental disabilities.

MRDDA must ensure that Individual Habilitation Plans (IHPs)¹ are developed for each client and that treatment services provided are consistent with these plans. MRDDA must operate in accordance with the Pratt/Evans Consent Decree, a court order first issued in 1978 in the Joy Evans class action lawsuit.² The court order establishes specific requirements pertaining to IHPs and other case management issues, requires the establishment of a system for monitoring MRDDA community-based residential programs, and specifies the time-frame within which payments must be made to vendors providing services to the mentally retarded and developmentally disabled. During the period under review, MRDDA was, and continues to be, responsible for providing the following services:

- placement services;
- housing services;
- training;
- habilitative services;
- case management services - individual habilitation plans and individual financial plans;
- mental health services, including day treatment; and
- program monitoring and oversight.

¹ Pursuant to Sections 403 and 504 of D.C. Law 2-137, D.C. Code, Sections 6-1943 and 6-1964, persons seeking commitment or admission must receive, prior to commitment or within 30 days of admission and annually thereafter, a comprehensive evaluation and individual habilitation plan. The plan should contain: (1) a statement of the nature of the specific strengths, limitations and needs of the person who is the subject of the plan; (2) a description of intermediate and long-range habilitation goals with a projected timetable for their attainment; (3) a statement of, and an explanation for, the plan of habilitation designed to achieve these intermediate and long-range goals; (4) a statement of objective criteria, and an evaluation procedure and schedule for determining whether the goals are being achieved; (5) a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals; and (6) criteria for release to less restrictive settings for habilitation and living, including criteria for discharge and a projected date for discharge if commitment is recommended by the plan.

² Joy Evans was the name of the plaintiff who initially filed suit against Forest Haven on behalf of mentally retarded residents institutionalized at Forest Haven. Judge Pratt is the judge who heard the case and rendered the opinion. The residents who benefit from this case are commonly referred to as Pratt/Evans class members.

Forest Haven

Forest Haven, the District's only institution for mentally retarded and developmentally disabled persons, was closed in 1991 as a result of the Joy Evans class action lawsuit. The lawsuit was filed on behalf of the residents of Forest Haven. A consent decree issued by the Court required the District to provide services in the least restrictive setting and to change its placement of residents from institutional to community-based living arrangements. As a result of efforts to deinstitutionalize the placement of mentally retarded and developmentally disabled individuals, the District began to place these individuals in contractor operated community-based residential facilities.

By definition, a community residential facility (CRF) is to provide a certain level of health care in a safe, hygienic, protective/sheltered living arrangement for one or more individuals who are not related by blood or marriage to the Residence Director. This level of health care is for individuals who require 24-hour supervision or assistance within a protected environment because of physical, mental, familial, or social circumstances.

Four types of community residential facilities are used to house persons diagnosed with mental retardation or a developmental disability in the District of Columbia. MRDDA has established a definition and eligibility criteria for placement in each of the four types of facilities. According to MRDDA, the definitions and criteria for placement in each type of facility are:

I. Intermediate Care Facility for the Mentally Retarded(ICF/MR)

An ICF/MR, a special category of group home for the mentally retarded (GHMRP), is a licensed residential facility that is certified and substantially funded through Title XIX (Medicaid). ICF/MRs provide active treatment for 4 to 8 clients. Active treatment is an aggressive and organized effort to enable each client to reach their fullest capacity. Twenty-four hour coverage is provided by live-in or shift staff. Each client must have an IHP containing behaviorally stated goals and objectives that are based on an appropriate assessment of the individual's needs and strengths. According to MRDDA, clients in this type of facility must meet the following criteria:

- have impaired functioning;
- require 24-hour supervision;
- require active treatment through an integrated program of therapies and other activities developed and supervised by medical and rehabilitative professionals, as appropriate, in order to improve the individual's ability to function independently;

- are likely to remain dependent without aggressive and consistent training;
- have significant developmental deficiencies (eating, dressing, hygiene, toileting, communication, i.e. understands only simple commands);
- are limited in their ability to apply skills learned in training situations to other settings and environments;
- are limited in their ability to care for most personal needs and make basic needs and wants known to others;
- are limited in their ability to work at competitive wage levels without support; and
- are unable to engage properly in social interactions.

As of September 30, 2000, according to MRDDA, there were 132 ICF/MRs housing a total of 816³ clients in the District of Columbia.

II. Group Homes for Mentally Retarded Persons (GHMRP)

Group Homes for Mentally Retarded Persons (GHMRP) are licensed facilities that house 4 to 8 clients. Each client must have an IHP containing behaviorally stated goals and objectives that are based on an appropriate assessment of the individual's needs and strengths. Group homes for the mentally retarded and developmentally disabled are funded with District appropriated dollars and are operated by private vendors under contract with MRDDA. Clients in this type of facility must meet the following criteria:

- require a moderate to high level of supervision on a 24-hour basis but are capable of basic self-help skills;
- are not a danger to self or others;
- can participate in a day program;
- may require developmental or independence training in preparation for movement to a semi-independent living situation; and
- may have moderate expressive and receptive communication abilities.

As of September 30, 2000, according to information supplied by MRDDA, there were 32 GHMRPs housing 177 clients in the District of Columbia.

³The Auditor was issued two different numbers regarding clients in ICF/MRs. A total of 768 clients was provided by MRDDA and a total of 816 was provided by the Medical Assistance Administration (MAA). The Auditor chose the MAA number because MAA produced a more reliable number based on a computer printout of payments from Medicaid.

III. Specialized Home Care (Adult Foster Homes)

Specialized Home Care is provided by a family within a private home for three or less adults under a Specialized Home Care Agreement between MRDDA and the Specialized Home Care Provider. The home must be approved by MRDDA. Each client must have an IHP containing behaviorally stated goals and objectives that are based on an appropriate assessment of the individual's needs and strengths. Specialized Home Care arrangements are funded with District appropriated dollars. Clients in this type of facility must meet the following criteria:

- require a moderate to high level of supervision on a 24-hour basis but are capable of basic self-help skills;
- are not a danger to self or others;
- can participate in a day program;
- may require developmental or independence training in preparation for movement to a semi-independent living situation; and
- may have moderate communication abilities, expressive and receptive.

As of September 30, 2000, MRDDA reported that there were 34 adult foster homes providing care to 79 clients in the District of Columbia.

IV. Supervised Apartment

A supervised apartment is typically a shared living arrangement for 2 to 5 clients with drop-in supervision by MRDDA staff. Supervised apartments may be single units grouped in a cluster within an apartment complex, or scattered throughout a complex. Each client must have an IHP containing behaviorally stated goals and objectives that are based on an appropriate assessment of the individual's needs and strengths. Supervised apartments are funded with District appropriated dollars under contractual arrangements with vendors providing services to the mentally retarded and developmentally disabled. Clients in this type of facility must meet the following criteria:

- require a minimal level of supervision;
- have basic self-help skills;
- are capable of communicating needs;
- can participate in supported or competitive employment;
- are capable of basic survival skills;
- are able to perform daily living tasks (such as cooking and shopping);

- are travel trained or capable of being travel trained; and
- are consistent in demonstrating positive, non-destructive behavior.

As of September 30, 2000, MRDDA reported that there were 16 apartments housing 85 clients in the District of Columbia.

Group Home Regulatory Agencies

The Auditor determined that the following three agencies are responsible for monitoring community residential facilities used to house clients receiving services through MRDDA:

1. The Department of Health, Licensing Regulation Administration (LRA) is responsible for monitoring all licensed facilities. Within LRA, there are two divisions regulating these facilities: the Health Care Facilities Division (HCFD), which is responsible for inspecting, regulating and licensing all ICF/MRs; and the Human Services Facilities Division (HSFD), which is responsible for inspecting, regulating and licensing all other GHMRPs.
2. MRDDA is responsible for monitoring the Specialized Home Care facilities (adult foster homes) and supervised apartments. Specifically, the client's case manager monitors these facilities.
3. The Department of Consumer and Regulatory Affairs' (DCRA) Fire Protection Division (FPD) and the Building and Land Regulation Administration (BLRA)- the FPD is responsible for conducting annual fire inspections for all licensed facilities. Additionally, DCRA is responsible for conducting a fire inspection of all facilities requiring a certificate of occupancy. Also, the BLRA is responsible for inspecting facilities requiring a license or certificate of occupancy to ensure that the facilities are in compliance with the District of Columbia's building code.

All ICF/MRs and GHMRPs are identified in Attachments I and II, which lists the owner/operator's name, address, ward in which the ICF/MR or GHMRP is located, the number of beds, and the type of facility.

FINDINGS

SPECIALIZED HOME CARE FACILITIES (ADULT FOSTER HOMES) AND SUPERVISED APARTMENTS ARE NOT REQUIRED TO BE LICENSED

The Auditor found that Specialized Home Care facilities (adult foster homes) which provide 24-hour supervision to adults are not required to be licensed by LRA if they are providing services to three or less persons. The Auditor also found that these facilities : 1) are not monitored by LRA, 2) have not received annual fire inspections; and 3) are not inspected by DCRA to ensure compliance with District of Columbia fire and building codes. Further, Supervised Apartments housing MRDDA clients are required to obtain a certificate of occupancy or to undergo an initial inspection by DCRA for compliance with the District's fire and building codes. However, after the initial inspection, these facilities do not receive any subsequent annual fire inspections.

The Auditor inquired of MRDDA regarding the policies and procedures used to ensure the health and safety of clients in these facilities. MRDDA officials indicated that:

- In the Specialized Home Care Agreement, providers agree to voluntarily comply with the municipal regulations governing Group Homes for Persons with Mental Retardation (22 DCMR, Chapter 35). However, the Auditor found that, without a licensing requirement mandating annual fire, environmental and safety inspections, there is no way for the District to ensure that a facility is voluntarily complying with these regulations.
- An initial home study is conducted by the client's case manager and MRDDA's Residential Resources Division. MRDDA conducts the initial home study to ensure that the facility can provide a safe and healthy environment for the client. After placement, case managers conduct drop-in visits on an as needed basis.

The Auditor found that case managers and employees of the Residential Resources Division have not been trained to evaluate compliance with: 1) District of Columbia building and fire codes; and 2) the environmental and safety requirements set forth in 22 DCMR, Chapter 35, governing Group Homes for Persons with Mental Retardation. Thus, without adequate training, these employees cannot effectively and efficiently inspect Specialized Home Care facilities and Supervised Apartments to ensure compliance with the District's fire and building codes or the requirements set forth in 22 DCMR, Chapter 35.

RECOMMENDATIONS

The Auditor recommends that the Council of the District of Columbia consider requiring that all facilities housing MRDDA clients, including adult foster homes and apartments, be licensed in order to ensure that they are: 1) regularly inspected; 2) adhering to District of Columbia health and safety regulations; and 3) that facility providers are fulfilling their fiduciary and contractual obligations to ensure the health and safety of MRDDA clients. The licensure requirement would also reveal whether these facilities are adhering to the District's building and fire codes.

LRA IS NOT TIMELY CONDUCTING ANNUAL INSPECTIONS OF ICF/MRs AND GHMRPs

LRA Is Not Conducting Annual Inspections Prior to License Expiration

Section 3102.4 of Title 22 of the DCMR states:

A facility shall submit an application for licensure renewal to the director [Department of Health] no later than ninety (90) days before the expiration date of the current license.

Facilities that timely file a renewal application are authorized to continue operation until the Department of Health responds to the application. D.C. Code, Section 32-1302(d), authorizes the continued operation of CRFs that timely filed a renewal application and provides the following:

The continued operation of a facility or agency pending action by the Mayor on an application for licensure renewal or initial licensure...shall not be deemed unlawful if a completed application was timely filed, but through no fault of the facility or agency or its governing body, staff, or employees, the Mayor has failed to act on the application before the expiration of the facility's or agency's current license or ... its authorized period of operation.
[Auditor's Emphasis]

During the review period, the Director of DOH issued a letter to CRFs, that had timely filed a renewal application, authorizing them to continue operating after the license expired. Unless there was imminent danger to residents or some other emergency requiring closure, LRA did not take

action against a licensee who filed a renewal application 90 days before the expiration date of the current license, and whose license had expired, if said licensee was waiting for LRA to respond to the renewal application.

The Auditor tested all 132 ICF/MRs and found that all facilities were adhering to Section 3102.4 by filing a license renewal application approximately 90 days prior to the expiration of their current license. However, the Auditor found that LRA failed to timely perform annual inspections and to ensure that these facilities' licenses were renewed before or at the time their existing licenses expired. The Auditor found that:

- 48, or 36%, of the 132 facilities did not receive an annual inspection in fiscal year 1998 prior to license expiration. Some examples included 6010 Dix Street NE; 1814 Bunker Hill Road NE; 1321 Emerson Street NW; and 4345 Wisconsin Avenue NW;
- 9, or 6%, of the 132 facilities did not receive an annual inspection in fiscal year 1999 prior to license expiration. Some examples included 927 55th Street NE; 6634 Eastern Avenue NW; 7533 12th Street NW; and 7129 7th Street NW; and
- 14, or 41%, of 34 facilities with licenses expiring as of June 30, 2000, did not receive an inspection prior to license expiration. Some examples included 703 Randolph Street NW; 3815 Albermarle Street NW; 4815 Chesapeake Street NW; and 1419 Van Buren Street NW.

The Auditor questioned officials at DOH as to why renewal applications were not processed in a timely manner. DOH officials provided the following justifications:

1. Although currently staffed with 7 inspectors, as of September 30, 2000, LRA had only 4 HCFD inspectors in fiscal years 1998, 1999 and most of 2000. HCFD inspectors are responsible for inspecting the 132 ICF/MRs.

Additionally, staffing levels for HFSD inspectors, who are responsible for the inspection of GHMRPs, decreased from 13 in fiscal years 1997 and 1998 to 4 as of September 30, 2000. In addition to the inspection of the 32 GHMRPs housing MRDDA clients, the 4 HFSD inspectors are also responsible for inspecting approximately 223 other CRFs in the District of Columbia.

2. Inspectors spent additional time investigating an increased number of reported unusual incidents and complaints, which reduced the amount of time available for their regular inspection duties.

Due to the lack of timely annual inspections, these facilities operated an average of 38 days on an “extended” license during fiscal years 1998, 1999 and 2000. Additionally, the Auditor documented four facilities in fiscal year 1998 that operated on an extended license for over 90 days, one facility in fiscal year 1999 that operated for over 120 days on an extended license, and three facilities that operated on an extended license for over 120 days in fiscal year 2000, as of June 30, 2000.

The purpose of the annual inspection is to determine regulatory compliance and allows LRA to ensure that the deficiencies are immediately corrected, thus preventing an emergency situation and eliminating known health and safety risks. The failure to provide adequate resources to LRA to facilitate the timely inspection and renewal of health care facilities’ licenses unnecessarily places mentally retarded and developmentally disabled clients’ health and safety in danger.

Fire Inspections Are Not Being Conducted In Accordance With District Law

The Auditor found that fire inspections of ICF/MRs and GHMRPs are not conducted in accordance with current District of Columbia law. Pursuant to the Omnibus Regulatory Reform Amendment Act of 1998, D.C. Law 12-86, Title 5, sections 501 and 502, annual fire inspections of ICF/MRs and GHMRPs must now to be conducted by DCRA rather than the Fire Department. According to the Fire Marshal, this law transferred all the functions of the Fire Chief, in the fire prevention code, to the Director of DCRA.

Prior to the passage of D.C. Law 12-86, which became effective April 29, 1998, the Fire Chief of the District of Columbia was charged with the duty and responsibility of enforcing the provisions of the District of Columbia Fire Prevention Code, including the following:

1. conducting all inspections of ICF/MRs and GHMRPs to determine compliance with fire safety requirements;
2. submitting to the Director [of DOH] the findings from fire inspections with a determination regarding licensure of a facility. The Director was required to incorporate the determination in the licensure recommendation; and

3. taking the appropriate action against an ICF/MR or GHMRP for noncompliance.

D.C. Law 12-86 abolished the Fire Chief's position as the "Code official" responsible for the enforcement of the Fire Prevention Code and the annual inspection of ICF/MRs and GHMRPs.

The Auditor found that DCRA has never implemented a program of conducting annual fire inspections of ICF/MRs or GHMRPs since the passage of the Omnibus Regulatory Reform Amendment Act. Further, the Auditor found that DCRA has no policies, procedures, or other systems in place to ensure that annual fire inspections of ICF/MRs and GHMRPs are conducted. Further, DCRA has not added staff necessary to conduct annual fire inspections required by law. Thus, mentally retarded and developmentally disabled residents in these facilities are at a great risk of harm from fire hazards that may exist in these facilities.

In response to the Auditor's inquiries as to why annual fire inspections are not being conducted, DCRA officials stated that they were still trying to "iron out" the specifics of an agreement with the Office of the Fire Marshal. These specifics have been partially addressed with a Memorandum of Agreement (MOA) between DCRA and the Fire Department, which in effect reassigns the enforcement of the fire prevention code from DCRA to the Fire Department. The Auditor found, however, that this MOA was not entered into until September 14, 2000, over two years after the passage of D.C. Law 12-86. Bureaucratic excuses and inaction such as this are unconscionable given the risk of harm to MRDDA clients and potential liability to the District posed by DCRA's failure to conduct annual fire inspections as required by law. To partially bridge this regulatory gap, officials in the Fire Department indicated that they were conducting annual fire inspections of ICF/MRs and GHMRPs upon the request of LRA, even though they were not legally required to do so, and will continue to do so until legislation is passed clarifying their specific functions.

Annual Fire Inspections Are Not Being Conducted In A Timely Manner Prior To License Expiration

In addition to fire inspections not being conducted by DCRA in accordance with District law, the Auditor found that many facilities were not inspected for fire safety during the license renewal process. This violated 22 DCMR, Chapter 3104.1, which requires an on-site inspection of

a facility to determine compliance with fire safety requirements and the rules governing facility licensure prior to license expiration. The Auditor found that for:

- fiscal year 1998, 47, or 36%, of the 132 facilities did not receive an annual fire inspection prior to their license expiration;
- fiscal year 1999, 16, or 13%, of the 132 facilities did not receive an annual fire inspection prior to their license expiration; and
- fiscal year 2000, as of June 30, 2000, 11, or 32%, of the 34 facilities with licenses expiring June 30, 2000 did not receive an annual fire inspection prior to their license expiration.

RECOMMENDATIONS

The Auditor recommends that:

1. The Director of DOH provide LRA with sufficient resources to increase staffing levels for facility inspectors thereby facilitating timely, thorough health and environmental inspections prior to license expiration.
2. DCRA immediately conduct annual fire inspections of all ICF/MRs and GHMRPs in accordance with D.C. Law 12-86.
3. The Council of the District of Columbia consider enacting legislation requiring the Fire Marshal of the District of Columbia to conduct annual fire inspections of all facilities housing mentally retarded and developmentally disabled clients served by the District of Columbia.
4. LRA should ensure that annual fire inspections of ICF/MRs and GHMRPs are conducted in a timely manner.

THE PROCESS OF MONITORING AND REGULATING ICF/MRs AND GHMRPs NEEDS SUBSTANTIAL IMPROVEMENT

LRA Is Failing To Ensure That ICF/MRs and GHMRPs Abate Deficiencies

LRA is the entity mandated by 22 DCMR, Chapter 31, to conduct annual inspections of ICF/MRs and GHMRPs. For deficiencies found during annual inspections, ICF/MR and GHMRP providers are issued a statement of deficiencies (SOD) for conditions that violate 22 DCMR, Chapter 31 or Chapter 35. The deficiencies must be corrected within 30 days. Additionally, ICF/MRs are issued SODs if they violate the federal Conditions of Participation for ICF/MRs.⁴ The provider signs the statement agreeing to the deficiencies found and is given 10 days in which to submit a Plan of Correction (POC), along with a date as to when the deficiencies will be abated. The deficiencies are expected to be corrected within 30 days. The Auditor found that, during the review period, LRA inspectors documented deficiencies that included, but were not limited to:

- allegations of inappropriate sexual contact between a client and a staff member;
- failure to prohibit the employment of an individual with a prior history of alleged abuse;
- failure to prohibit the employment of an individual with a criminal conviction of assault;
- failure to provide or obtain preventive and general medical care for clients;
- failure to report incidents of physical abuse of a client by staff members. In one facility, five such cases were discovered;
- failure by staff to follow physician's orders regarding medication administration;
- failure to provide necessary equipment to meet the client's needs, specifically a van with wheelchair lift, where 3 of the 6 clients required the use of wheelchairs for their mobility;
- failure to provide staff with proper behavior management plans and training in the care of clients; and

⁴The federal Conditions of Participation for ICF/MRs permitting Medicaid funding are set forth in 42 CFR 483.400 through 483.480. The conditions prescribe minimum standards that ICF/MRs must adopt, and includes requirements related to facility management, client protections, staffing, treatment services, behavior management, health care services, physical environment, and dietetic services.

- lack of active programs in facilities for the prevention, control, and investigation of infectious and communicable diseases.

In each of the above cited cases, the provider submitted a monitoring plan of correction (POC) which was accepted by LRA. Despite the seriousness of the deficiencies, the Auditor found that LRA failed to conduct an investigation or unannounced visit to ensure that the POC had been implemented and that the deficiencies had been abated.

The Auditor found that, despite the issuance of SODs, LRA rarely revisited a facility to ensure the abatement of cited deficiencies. Table I presents the Auditor's findings regarding LRA's follow-up visits to facilities issued SODs during fiscal years 1998, 1999, and 2000.

Table I
LRA Scheduling Report
Documenting Follow-Up Visits for Facilities
Issued Statements of Deficiencies

Fiscal Year	Number of Surveys and Investigations Conducted by LRA ⁵	Surveys Resulting in the Issuance of an SOD	Number of SOD Reinspections Conducted by LRA	% of SOD Reinspections Conducted by LRA
1998	172	155	12	7%
1999	132	128	7	5%
2000	66 ⁶	63	10	16%
Total	370	346	29	

Source: The Department of Health, Licensing Regulation Administration

It should be noted that of the 346 SODs issued in fiscal years 1998, 1999 and 2000, LRA conducted only 29 revisits to ensure that cited deficiencies were abated. This amounted to only 8% of all SODs issued.

The Auditor further found that of the 63 SODs issued in fiscal year 2000, serious deficiencies were identified in 16 facilities. These deficiencies generated specific recommendations for summary suspension, revocation of license, denial of license renewal, or cancellation of the facility's Medicaid agreement. Despite such serious deficiencies, LRA revisited only 4 of the 16 facilities to ascertain whether the deficiencies had been abated. The failure to revisit all 16 facilities violated DOH's

⁵Includes annual inspections, initial licensure inspections and inspections in response to complaints and unusual incidents.

⁶ As of June 30, 2000.

internal policy set forth in 5-HSFD-003, which states: “The inspector shall conduct a follow-up inspection within 10 days following the 30-day correction period to validate the abatement of the cited violations.” In response to the Auditor’s inquiry as to why there were so few follow-up visits to facilities issued SODs, LRA officials indicated that understaffing and the need to meet annual inspection schedules for license renewal, in addition to investigating unusual incidents and complaints, contributed to an inadequate number of follow-up inspections.

Additionally, the Auditor found that, in each of the 4 cases, the follow-up visits resulted in a finding of non-compliance with the recommendations. The revisits also generated a further recommendation to the Medical Assistance Administration (MAA) to terminate these facilities’ participation in the Medicaid program. Of the 4 facilities, one facility did not abate the deficiencies and the facility’s Medicaid agreement was terminated.

LRA Is Not Providing MRDDA Officials With Results of Annual Inspections And Surveys

There are currently no policies, procedures, regulations, or laws requiring LRA to provide MRDDA with monitoring reports or the results of unusual incident or complaint investigations. Although LRA has the legal responsibility for ensuring that a facility is in compliance with 22 DCMR, Chapter 35, in addition to the federal Conditions of Participation for ICF/MRs, it is not mandated to provide the results of its monitoring and investigation of ICF/MRs and GHMRPs to MRDDA. Thus, where there should have been extensive coordination, cooperation, and information sharing between DOH (LRA) and DHS (MRDDA), the Auditor found a near total communication disconnect between these agencies as it relates to the regulation of ICF/MRs and GHMRPs.

Through discussions with MRDDA officials, the Auditor discovered that the only time LRA provides a facility inspection report or survey report to MRDDA is in a life threatening situation where clients need to be moved to another facility, if a facility’s license was revoked or if the facility was subject to closing.

MRDDA’s System of Monitoring is Placing Clients at Risk

Prior to 1995, MRDDA had its own monitoring unit staffed by 20 employees. According to MRDDA officials, this unit was abolished in 1995 as a result of budget cuts and because the unit was viewed as a duplication of services provided by DCRA, which also had a Program Monitoring and Enforcement Unit.⁷

⁷ Prior to the creation of the Department of Health pursuant to Reorganization Plan No. 4 of 1996, the Department of Consumer and Regulatory Affairs was responsible for licensing, inspecting, and monitoring GHMRPs. LRA was not transferred to DOH until fiscal year 1998.

MRDDA began monitoring facilities again in March 1999 due to the number of incidents and complaints registered against ICF/MRs and GHMRPs. MRDDA currently has four employees who split their duties between program monitoring, resource management, and facility monitoring. MRDDA officials could not provide the Auditor with written policies concerning health and safety standards used during monitoring visits.

The Auditor's review of MRDDA's fiscal year 2000 monitoring reports revealed that MRDDA's monitoring staff documented serious deficiencies in ICF/MR and GHMRP facilities including, but not limited to:

- no criminal background checks for facility staff;
- lack of current food handlers license;
- lack of first aid training certification;
- improperly maintained medication records for clients; and
- lack of medical examinations for staff members.

Despite these deficiencies, the Auditor found that MRDDA continued to place new clients and leave existing clients in the affected facilities.

The Auditor also found that MRDDA has no legal authority to close a facility, revoke a facility's license, or issue a civil infraction for noted deficiencies that are not corrected. MRDDA officials stated that the only authority they have is to remove a client from a facility.

Currently, LRA is the only agency with enforcement authority over ICF/MRs and GHMRPs. This authority is set forth in 16 DCMR 3239.1 through 3239.3, and allows LRA to issue civil infractions to facilities found out of compliance with applicable regulatory requirements. LRA also has the authority to suspend or revoke a facility's license or deny renewal of a license.

In response to the Auditor's inquiry as to why LRA's enforcement authority is not used, MRDDA officials indicated that it involves a time consuming process. In order for an infraction to be issued, MRDDA officials must first notify LRA and LRA must then conduct its own inspection of the facility. Unless a life-threatening situation is found to exist, MRDDA officials attempt to work with the provider to abate the deficiencies.

MRDDA officials were asked to describe actions they take with regard to deficiencies cited in their monitoring reports or when MRDDA case managers find deficiencies while visiting clients. MRDDA officials indicated that if a facility does not voluntarily abate the deficiencies, they will not place additional clients in the hope that the loss of potential income will encourage a facility owner to abate the deficiencies. However, MRDDA officials indicated that this strategy is generally not

effective due to the shortage of available beds and the perception that many facility owners are aware of this shortage.⁸ In response to the Auditor's inquiry as to how often a client is placed in a facility with known deficiencies, MRDDA officials indicated that they do not keep a record of such placements, but added that it happens more often than they would like because of a shortage of facilities.

If the owner chooses to forgo additional client placements and chooses not to abate the cited deficiencies, the present system for deficiency abatement does not protect clients already in a facility.

MRDDA Is Not Monitoring Facilities Outside the District of Columbia That House the District's Mentally Retarded and Developmentally Disabled Clients

In order to comply with the Pratt/Evans Consent Decree and to meet the needs of a population requiring highly specialized services that are not being met by the limited provider base within the District of Columbia, MRDDA houses approximately 46, or 26%, of its GHMRP clients in facilities in Maryland, Illinois, Texas, Pennsylvania, Massachusetts, West Virginia and other jurisdictions. Facilities providing services outside the District of Columbia are not governed or regulated by the District of Columbia government. Instead, these facilities are regulated by the state in which they are located.

Facilities located outside the District must meet the health, safety and licensing standards and requirements of that jurisdiction. MRDDA officials indicated that if a case manager visits an out-of-state facility and finds deficiencies, MRDDA can then ask for licensing and inspection reports. However, neither MRDDA nor the District has any authority to compel an out-of-state facility to abate deficiencies. MRDDA's only remedy is to remove the client from the facility.

MRDDA's case managers are currently required to conduct 4 site visits per year of clients housed in out-of-state facilities. The Auditor found that MRDDA's staff is not conducting the required 4 site visits of out-of-state facilities housing MRDDA clients, with the exception of facilities in the State of Maryland. MRDDA case managers are presently conducting only telephone interviews with the client and provider. Without periodic on-site monitoring and inspections, the District cannot be adequately assured of the health and safety of clients living in out-of-state facilities.

⁸The Auditor found, however, that there are currently 1,036 beds available to house a total of 993 clients in ICF/MRs and GHMRPs in the District of Columbia. (see Attachment I) The Auditor is unable to determine whether the available beds adequately meet the specific needs of all MRDDA clients, or whether the available inventory of beds is sufficient to meet future required placements.

Criminal Background Checks Of Providers' Employees Are Not Conducted In Accordance With District Of Columbia Law And Regulations

Section 3509.9 of Title 22 of the DCMR states that each GHMRP shall obtain references on each employee and no GHMRP shall employ an individual with a history of the following:

1. child or resident abuse or abuse of someone under his or her care and supervision;
2. neglect;
3. exploitation; or
4. conviction of a sexual offense or violent crime.

Additionally, D.C. Law 12-238, the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, which became effective April 20, 1999, requires that no facility shall offer to employ or contract with any person who is not a licensed professional until a criminal background check has been conducted for the potential employee or contractor. Further, no facility shall employ or contract with any person who is not a licensed professional if that person has been convicted in the District of Columbia, or in any other state or territory of the United States, of any of the following offenses or their equivalent in another state or territory:

- murder, attempted murder, or manslaughter;
- arson;
- assault, battery, assault and battery, assault with a dangerous weapon, mayhem or threats to do bodily harm;
- burglary;
- robbery;
- kidnapping;
- theft, fraud, forgery, extortion or blackmail;
- illegal use or possession of a firearm;
- trespass or injury to property;
- rape, sexual assault, sexual battery, or sexual abuse;
- child abuse or cruelty to children; or
- unlawful distribution, possession, or possession with intent to distribute a controlled substance.

The Auditor found one vendor that operates a total of 11 facilities in the District of Columbia that was :

1. conducting only local criminal background checks;
2. hiring employees prior to receiving police clearance; and
3. continuing employment after receiving a police report that the employee had been convicted of one or more of the above offenses.

This practice was noted in an incident report received from the facility on August 16, 1999, alleging improper sexual contact between a client and staff member during early August 1999. It was discovered that the employee in question was hired prior to the provider receiving a police clearance (hire date April 13, 1999). The employee was also hired prior to receipt of a physician's certification (received July 15, 1999), which violated 22 DCMR 3509.6. On June 22, 1999, the provider received a police report which documented the employee's history of prior abuse. Even after this documentation was received, the provider continued to employ the individual until August 1999 when the employee was terminated.

The above case indicates that this vendor (who operates 11 facilities in the District of Columbia) did not adhere to D.C. Law 12-230 and proper employee screening procedures. The Auditor found that LRA did not review additional employee records to ascertain whether this vendor had a pattern of hiring employees who had been convicted of disqualifying offenses established under D.C. Law 12-238.

LRA's inconsistent method of monitoring ICF/MRs and GHMRPs and overseeing the abatement of deficiencies found therein must be substantially improved in order to protect the health, safety, and welfare of mentally retarded and developmentally disabled persons housed in such facilities.

RECOMMENDATIONS

The Auditor recommends that:

1. The Director of DOH provide sufficient resources to increase the number of LRA facility inspectors in order to timely conduct follow-up visits to deficient ICF/MRs and GHMRPs to validate the abatement of noted deficiencies.
2. LRA must conduct follow-up visits within 30 days of the issuance of a statement of deficiencies to determine whether the cited deficiencies have been abated.

3. MRDDA and LRA must establish a policy of sharing monitoring results. Timely sharing of such information would accelerate the process of deficiency correction in the event that deficiencies are discovered by an MRDDA case manager prior to LRA's annual site visit. Providing MRDDA with LRA monitoring reports could also prevent the possible placement of a client in a facility with unabated deficiencies.
4. Periodic on-site monitoring of out-of-state facilities must be reestablished to ensure the health and safety of clients residing in these facilities.
5. Providers should be required to maintain strict compliance with the criminal background check requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998 or face immediate monetary and other sanctions. Further, LRA must strictly enforce these sanctions.
6. Verification of criminal background checks should be instituted as part of LRA's annual monitoring process.

MONITORING OF CARE PROVIDED TO MRDDA CLIENTS NEEDS IMPROVEMENT

Case Management Ratios Are Too High

In addition to coordinating and advocating for the delivery of services to mentally retarded and developmentally disabled clients, MRDDA case managers also participate in the assessment of individual client needs.⁹ According to the American Association on Mental Retardation (AAMR), "the number of individuals each case manager or service coordinator works with will need to be kept to a minimum in order to ensure the service coordinator or case manager has the opportunity to establish strong working relationships with individuals and families." In achieving this goal, the Association for Retarded Citizens (ARC) has stated, "in general, good practice is for each service coordinator or case manager to serve no more than 25-30 individuals. However, there are circumstances when a service coordinator or case manager can serve only 10-15 people effectively because of various factors, such as intensity of need, geographic location, crisis situations and age of individuals."

The Auditor found that MRDDA was staffed with 37 case managers as of September 30, 2000. This figure was up from 29 case managers in fiscal year 1999. The Auditor further found that each case manager had an average caseload of approximately 54 clients which exceeded the case

⁹Assessment of individual client needs as used by the Auditor does not mean clinical assessment. When discussing clinical assessment the term "clinical assessment" will be used.

manager to client ratio suggested by the Association for Retarded Citizens by 24 to 29 clients. MRDDA officials indicated that their case manager to client ratio is so high because budgetary constraints prevented them from hiring additional case managers during the review period.

The Auditor found that the Pratt/Evans Consent Decree mandates MRDDA's case managers to conduct a minimum of four home visits and day program visits each year for each client, which is a combined total of 216 home and day program visits each year for the 54 clients in the case managers caseload at the time of this examination.

MRDDA Is Having Difficulty Recruiting Qualified Case Managers

Officials at MRDDA stated that they are mandated by the Pratt/Evans Consent Decree to establish a case manager to client ratio of 30 to 1 by December 2000. As stated earlier, during the period under review, each MRDDA case manager's caseload averaged 54 clients.

MRDDA officials indicated they are encountering difficulties in recruiting qualified case managers. Cited impediments included:

- an unusually high case manager to client ratio;
- the amount of time MRDDA case managers must spend filing court ordered documentation, which is one of the duties included in the case manager's position description; and
- the level of work in relation to the salaries paid for these positions.

According to MRDDA case management officials, prior to fiscal year 2000, MRDDA preferred that case managers have a masters degree in a social science and 2 to 3 years of experience working with persons with mental retardation or developmental disabilities. As a result of recruitment difficulties, MRDDA no longer anticipates that new case managers will have a masters degree in a social science. Instead, MRDDA is actively recruiting persons with a bachelors degree in a social science, with 2 to 3 years of experience working with persons with mental retardation or developmental disabilities. By easing the educational standard, MRDDA runs the risk of assigning MRDDA clients to case managers who may not have the educational background and experience necessary to adequately serve persons with mental retardation or developmental disabilities.

MRDDA Is Not Providing Continuing Education Opportunities To Case Managers

The Auditor found that, once hired, MRDDA case managers are provided with training/orientation in the following areas:

- getting to know MRDDA;
- getting to know the case management division within MRDDA;
- introduction to other MRDDA units impacting the case management division;
- case management- the job (i.e. sensitivity training, learning about people, policies and procedures, documentation, monitoring);
- Medicaid waiver procedures;
- unusual incident procedures; and
- an overview of the Pratt Decree.

The Association of Retarded Citizens (ARC) has recommended “that preservice training should not focus solely on clinical social work, but should also include community organizing, advocacy and continuing education to keep case managers abreast of state-of-the-art approaches.”

The Auditor found that MRDDA does not provide case managers with ongoing training in the care and monitoring of persons with mental retardation or developmental disabilities, nor does it have any continuing education requirements. This lack of continuing education does not ensure that case managers are remaining current with state-of-the-art approaches in the treatment and care of persons with mental retardation or developmental disabilities.

RECOMMENDATIONS

The Auditor recommends that:

1. The Director of DHS increase funding to hire more MRDDA case managers, thereby reducing the case manager to client ratio and improving MRDDA’s effectiveness in serving its clients. Recruitment efforts should include a means to attract persons with the highest level of education and experience possible.
2. The Administrator of MRDDA should require and afford case managers the opportunity for continuing education in order to remain current with state-of-the-art approaches in the treatment and care of persons with mental retardation or developmental disabilities.

SYSTEM FOR REPORTING UNUSUAL INCIDENTS, COMPLAINTS AND DEATHS IS POORLY MANAGED

Pursuant to 22 DCMR 3599, an unusual incident is defined as any occurrence or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any way places the resident at risk. Unusual incidents may include, but are not limited to, natural disaster or other events which cause damage to the facility or threaten the residents, outbreaks of disease, filing of bankruptcy, labor disputes, any event which may interfere with the operation of the facility, allegations or incidents involving neglect, abuse, assault, sexual assault of a resident, sudden death of a resident, and allegations or incidents of drug possession or distribution by a staff person.

Until emergency rules were adopted December 22, 1999, there were no District of Columbia regulations requiring that ICF/MRs or GHMRPs report unusual incidents to DOH or MRDDA. Sections 3513.1(g), 3519.5 and 3519.6 of Title 22 of the DCMR required only that facilities:

1. maintain a log in which emergencies and other unusual occurrences involving residents are recorded by the responsible person on duty at the time of the occurrence;
2. document each emergency and enter the follow-up actions into the resident's permanent record which shall be made available for review by authorized individuals; and
3. after medical services have been secured, each GHMRP or ICF/MR shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight hours after the incident.

The recently promulgated rules make it mandatory to report all unusual incidents immediately. Section 3519.10 of Title 22 now states:

In addition to the reporting requirement in Section 3519.10, each GHMRP must notify the Department of Health, Health Facilities Division, of any unusual 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. Such notification shall be made by telephone immediately and shall be followed up by written notification within 24 hours or the next work day.

Despite the promulgation of the rules, the District is still not prepared to timely investigate unusual incidents (UIs) reported because of inadequate staffing and related resources.

Requirements For Reporting All Unusual Incidents and Deaths Of MRDDA Clients Is Inadequate

The Auditor found that Section 3519.10 applies only to the reporting of unusual incidents which occurred in ICF/MRs and GHMRPs licensed by DOH. The rule failed to address the reporting of unusual incidents:

1. occurring to residents living in adult foster homes, respite centers, apartments or with their natural families;
2. occurring in day treatment program facilities;
3. occurring to clients while in the care of transportation providers; and
4. discovered by District government employees, such as MRDDA case managers, during home visits.

The Auditor questioned officials at MRDDA and LRA regarding procedures for reporting UIs that occur in the above four situations. In response, the Auditor was provided an interagency agreement between DOH and DHS, No. JP-DD-1003 effective December 30, 1999, which mandated the reporting of incidents including deaths, injuries, abuse, neglect, or mistreatment of persons with mental retardation and developmental disabilities. The interagency agreement also applies to persons receiving services and supports (including transportation) from providers that are reimbursed pursuant to a contract, Medicaid provider agreement, or other provider agreement with the Government of the District of Columbia. The scope of the policy applies to all providers, their employees, contractors, and District of Columbia government employees who provide services and support to clients, and who: 1) were involved in an incident, 2) observed an incident, or 3) have knowledge of an incident. JP-DD-1003 requires:

1. the execution of a District of Columbia incident report form documenting activities, behaviors, actions or inactions, and witnesses associated with each incident;
2. submission of a completed incident report to the MRDDA Duty Officer by facsimile in MRDDA's Program Operations Division (POD). In the event a facsimile is not possible, the incidents are to be reported to the Duty Officer at "Answers, Please!", an information and referral registry located within DHS. The Duty Officer or Community Resources Advisor is to then complete an accurate accounting of the events reported by telephone and forward this report to the Duty Officer at POD; and

3. District of Columbia employees to: 1) immediately report all incidents to their supervisor; 2) send an incident report to the POD; and 3) phone in a verbal report to DHS at “Answers, Please!”.

In addition to the above, the policy requires ICF/MRs to submit a completed incident report to LRA. Community Residential Facilities and Foster/Respite Care Providers are to file the report with the POD Duty Officer.

The policy also states: “Each provider shall be held responsible for ensuring that its employees report incidents pursuant to this policy. Failure to comply with this policy will result in sanctions and/or penalties from the District of Columbia Government.” In essence, providers are given two separate sets of procedures to follow in the reporting of unusual incidents. These procedures differ in two ways: 1) who is required to report unusual incidents, and 2) where the unusual incidents are to be reported.

The Auditor also found that the procedures for reporting client deaths are unclear. As stated earlier, rules now require the reporting of all deaths in ICF/MRs and GHMRPs to LRA. Again, these rules apply only to licensed facilities.

Officials at MRDDA also provided the Auditor with an interagency agreement between DOH and DHS, (JP-DD-1001 effective December 20, 1999) which requires that direct care staff and transportation staff for persons with mental retardation or developmental disabilities report the death of such clients immediately to: 1) emergency assistance 911; 2) the Office of the Chief Medical Examiner; 3) the DHS Hotline at “Answers, Please!”; and 4) the Fatality Review Committee.¹⁰ This policy applies to all direct care and transportation staff employed by providers pursuant to a Medicaid provider agreement or contract with the District of Columbia government. Providers are supplied with two separate procedures for reporting the deaths of MRDDA clients, the first being rules requiring the reporting of client deaths to LRA only, and the second being DOH and DHS policies requiring that facilities report client deaths to LRA and to the four external agencies listed above.

¹⁰Mayor’s Order 2000-41, dated March 3, 2000. The purpose of the Fatality Review Committee is to examine events and circumstances surrounding the deaths of residents in the District with mental retardation or a developmental disability. This Committee is to: 1) review the deaths of persons living in a licensed health care entity, identify the cause, identify and evaluate services provided to persons with mental retardation and developmental disabilities; 2) develop and monitor plans for the implementation of recommendations to improve and maximize systemic responses to incidents of abuse, neglect and maltreatment; and 3) propose amendments to statutes, policies and procedures, modifications to relevant service delivery, training, and coordination of services to reduce any form of maltreatment. The committee, whose members are appointed by the Mayor, is to meet quarterly and a minimum of 15 members shall be present in order to constitute a quorum. Also, the committee is to provide to the Mayor, by the last Friday in January of each year, an annual report which contains data on all fatalities, reviews, recommendations and status of these recommendations.

The Auditor found the following deficiencies in the incident reporting process:

1. Providers and vendors are not using the District of Columbia incident report form. Instead, providers and vendors are using their own forms which do not always contain the information that has been requested on the District form.
2. Not all unusual incident reports are being sent to MRDDA's POD. The Auditor documented that UI reports are being sent directly to a number of different agencies, including DOH, DHS and the D.C. Child and Family Services Administration without being forwarded to MRDDA. Instead of UIs being sent to POD, the Auditor found that UI reports were sent to various offices such as case management and administrative services within MRDDA. MRDDA officials indicated they found reports that had been in another office within MRDDA for several months before being forwarded to POD for logging into the system and forwarding to external agencies such as the MPD, DHS' OIC, and Adult Protective Services. Additionally, the Auditor documented UI reports sent directly to LRA that were investigated but never forwarded to MRDDA. In fact, LRA, in a letter to facility administrators, instructed ICF/MRs and GHMRPs that they must report an unusual incident to LRA within 24 hours, and makes no reference to reporting the incident to MRDDA. The failure to report all unusual incidents involving mentally retarded and developmentally disabled clients to MRDDA does not allow for: 1) the correct tracking and disposition of incidents; 2) the correct reflection of the number of unusual incidents; 3) the timely investigation of UIs ; and 4) assurance that all incidents are investigated and resolved.
3. MRDDA is unable to maintain adequate records of all UIs reported to their offices because of an inadequate system of reporting and the lack of appropriate information technology. The Auditor requested a report from MRDDA documenting the number of UIs reported to it, the number that were referred for investigation, and the disposition of these cases. The Auditor requested this report for the period December 22, 1999 through September 30, 2000. MRDDA officials were unable to provide the report, but provided the following justifications for their inability: 1) problems implementing MRDDA's database system, 2) a backlog of over 500 incidents not entered into the system, and 3) inadequate funding to implement an effective automated information management system.

4. ICF/MR providers are not reporting unusual incidents immediately which violates 22 DCMR 3519.10. During a review of fiscal year 2000 investigated incident reports at LRA, the first year this notification was required, the Auditor found that 19, or 46% , of the 41 unusual incidents reported as of June 30, 2000, were not immediately verbally reported, and were not reported in writing within 24 hours as prescribed by rule. The Auditor found no notation in the investigation reports indicating that these facilities were issued civil infractions for their failure to report the incidents as required by regulation.

The failure to report and record all unusual incidents does not allow for: 1) the correct tracking and disposition of incidents; 2) the correct reflection of the number of unusual incidents reported; 3) the timely investigation of UIs; and 4) the assurance that all incidents are promptly investigated and resolved.

As a consequence of the deficiencies, the Auditor found that the District of Columbia is still without an adequate and effective system for ensuring that all UIs, complaints, and deaths are reported in a thorough and timely manner. Thus, the health and safety of persons with mental retardation and developmental disabilities still cannot be adequately assured.

RECOMMENDATIONS

The Auditor recommends that:

1. Standardized policies, procedures and forms should be established for reporting unusual incidents and deaths. Further, the policies and procedures should apply to all individuals and organizations responsible for the care of persons with mental retardation or developmental disabilities. Policies and procedures should also be established to better coordinate the efforts of all agencies responsible for the investigation of UIs, complaints, and deaths of MRDDA clients to ensure thorough and timely investigations.
2. Existing regulations for reporting deaths must be reconciled with internal policies and procedures.
3. A database should be developed for use by all agencies responsible for reporting any unusual incidents to ensure that:
 - a. all unusual incidents are accounted for;
 - b. all unusual incidents, complaints and deaths are reported in a thorough and timely manner;

- c. there is a unified system for tracking unusual incidents, complaints, and deaths by vendor; and
- d. trend analysis can be conducted to detect unusual trends and patterns by facility and by provider.

INVESTIGATIONS OF UNUSUAL INCIDENTS, COMPLAINTS AND DEATHS ARE INADEQUATE

MRDDA Is Not Adequately Managing The Investigation Of Unusual Incidents

The Auditor's review of MRDDA's role in the investigation of unusual incidents indicated that the Program Operations Division (POD) is responsible for:

1. receiving, recording, and reviewing unusual incidents and complaints; and
2. forwarding the UI reports or complaints to the proper agency for investigation.

Pursuant to MRDDA policy No. JP-DD-1003, all incidents must be investigated by either MPD, the Office of the Chief Medical Examiner, Office of Inspector General, or other appropriate governmental agencies. The Auditor was informed by officials at MRDDA that for the past five years they have not had the funding to staff their Incident Management Unit with qualified investigators. When questioned about the investigation of unusual incidents, MRDDA officials indicated that they have forwarded unusual incidents to the Department of Human Services' Office of Investigations and Compliance (OIC), unless there are criminal allegations of abuse which are referred to MPD.

The Auditor found numerous deficiencies within the investigation process which are summarized below:

1. MRDDA case managers are conducting unusual incident investigations, in addition to their official duties. However, officials within POD stated that they have continued to receive unusual incident reports after a case manager has: 1) investigated the incident, and 2) rendered a disposition on the incident and closed the file.
2. MRDDA case managers have no legal authority to investigate unusual incidents and

have not been trained to conduct investigations of unusual incidents. The Auditor found that, without this training, the District cannot be assured that UI investigations are properly conducted.

3. Officials at MRDDA stated that most unusual incident reports they receive are forwarded to OIC. The Auditor found that OIC investigators also are not trained to investigate allegations of neglect or abuse. Additionally, the Auditor found that OIC has assigned only two persons to investigate all unusual incidents forwarded to it by MRDDA.
4. There is no well-coordinated effort within MRDDA to ensure that UIs are investigated and resolved effectively. MRDDA could provide no documentation indicating whether a case referred to an external agency had been investigated and resolved. This lack of tracking and follow up does not ensure the health and safety of mentally retarded and developmentally disabled clients receiving services through MRDDA.

Department of Human Services' OIC Is Not Investigating UIs In A Timely Manner

As stated above, MRDDA forwards UIs to OIC for investigation. Table II presents the total number of UIs reported and forwarded to OIC during fiscal years 1998, 1999 and 2000.

Table II
Unusual Incidents Referred To OIC

Case Type	Fiscal Year 1998	Fiscal Year 1999	Fiscal Year 2000	Total
Abscondence	22	43	22	87
Abuse/Neglect ¹¹	75	41	95	211
Accident	1	5	0	6
Arrest/Customer	2	4	0	6
Behavioral	0	110	0	110
Bomb Treat	0	2	0	2
Conflict of Interest	0	0	1	1
Contract/Violation	2	0	0	2
Death	2	11	9	22
Employee Misconduct	28	31	18	77
Fire	0	0	2	2
Fraud/Client	0	1	0	1
Illness	60	159	109	328
Injury	82	134	75	291
Theft/Burglary	3	6	5	14
Property Loss	1	0	0	1
Property Damage	4	0	0	4
Vehicular Accident	0	5	5	10
Other	0	2	6	8
Total	282	554	347	1,183

Source: Department of Human Services, Office of Investigations and Compliance

The Auditor found that, through full investigation or administrative review, OIC had closed only 479, or 40%, of the 1,183 UIs reported by MRDDA. Additionally, since March 26, 2000, OIC has been assisted by two attorneys from the Council on Quality and Leadership in Support of People

¹¹Includes neglect, behavioral abuse, physical abuse, sexual abuse and substance abuse.

with Disabilities. These attorneys have provided consultant services to assist OIC with MRDDA's UI backlog. The Auditor found that of the 704¹² outstanding UIs reported:

- 169, or 60 %, of the UIs reported in fiscal year 1998 had not been investigated as of September 30, 2000;
- 315, or 57%, of the UIs reported in fiscal year 1999 had not been investigated as of September 30, 2000; and
- 220, or 63%, of the UIs reported in fiscal year 2000 had not been investigated as of September 30, 2000.

¹²In an October 27, 2000 memorandum to the District of Columbia Auditor, OIC officials stated that a total of 493 cases remained in the backlog of MRDDA UI reports for fiscal years 1998, 1999 and 2000. In subsequent reports documenting UIs reported and investigated by type, the Auditor found the total number of outstanding UI reports to be 704.

Table III presents the 704 outstanding UIs, by type, for fiscal year 1998, 1999 and 2000.

Table III
Outstanding UIs For Fiscal Years 1998, 1999, and 2000

Case Type	Fiscal Year 1998	Fiscal Year 1999	Fiscal Year 2000	Total
Abscondence	12	23	14	49
Abuse/Neglect	53	29	60	142
Accident	0	3	0	3
Arrest/Customer	2	0	0	2
Behavioral	0	73	0	73
Bomb Treat	0	2	0	2
Conflict of Interest	0	0	0	0
Contract/Violation	1	0	0	1
Death	1	0	2	3
Employee Misconduct	7	16	13	36
Fire	0	0	1	1
Fraud/Client	0	1	0	1
Illness	39	84	72	195
Injury	51	76	49	176
Theft/Burglary	1	3	3	7
Property Loss	0	0	0	0
Property Damage	2	0	0	2
Vehicular Accident	0	3	3	6
Other	0	2	3	5
Total	169	315	220	704

Source: Department of Human Services, Office of Investigations and Compliance

As shown in the Table III, 60% of all UIs reported to OIC have not been investigated. Of the 704 uninvestigated UIs, 69%, or 484, occurred in fiscal years 1998 and 1999. It should also be noted that, 142, or 20%, of the 704 outstanding UIs involve cases of alleged abuse or neglect of MRDDA clients.

The District, in its failure to timely investigate and resolve these unusual incidents, is placing the health and safety of mentally retarded and developmentally disabled persons' lives in jeopardy by possibly having them remain in a situation of abuse or neglect.

LRA Is Not Adequately Conducting Investigations of Unusual Incidents

The Auditor also interviewed officials at LRA and reviewed unusual incidents reported to and investigated by LRA during fiscal years 1998, 1999 and 2000. The Auditor found that unusual incidents reported to LRA increased from a total of 17 during fiscal year 1998 to 41 as of July 27, 2000. The Auditor also found that LRA investigates all unusual incidents reported to its office under policies established by LRA's Health Facility Division (HFD). Under HFD policy No. 0006, effective July 30, 1998, HFD is to receive, record, and investigate all incidents. This policy includes, but is not limited to, emergency or life-threatening situations which have an immediate adverse effect on the health and safety of patients/residents in the District of Columbia. Although LRA adhered to the policy of investigating all incidents, the Auditor found that there were still numerous deficiencies in LRA's investigative process, including the following:

1. The Auditor found no evidence that LRA investigated unusual incidents noted in a facility's records during LRA's annual survey. The Auditor examined documentation of a case where a facility was internally investigating five separate cases of alleged abuse. The existence of an investigation had been recorded in the facility's records, and initially observed by LRA when reviewing the records during the annual survey. The facility had not reported these incidents to LRA. LRA was also made aware of the allegations through an anonymous complaint sent on October 24, 1997.¹³ LRA failed to investigate the allegations because the concerns addressed in the complaint were not part of the ICF/MR recertification process and the incident had not been reported to LRA directly. The Auditor found that LRA only investigated this complaint after the complainant re-submitted it on March 25, 1999, this time threatening to send the allegations to the media.
2. LRA is not investigating UIs in a timely manner. In accordance with LRA policy HFD No. 0006, LRA is to: 1) fully and impartially investigate all incidents in a timely manner,

¹³At the time of the initial complaint, the responsibility for licensing and monitoring ICF/MRs was under the jurisdiction of the Department of Consumer and Regulatory Affairs.

and 2) investigate an incident at the general time it was alleged to have occurred. The Auditor reviewed all unusual incident reports filed during 1998, 1999 and 2000. Table IV presents the results of this review.

Table IV
Auditor's Evaluation of LRA's Unusual Incidents Investigations

Fiscal Year	UIs Reported to LRA	Number Of UIs Received, Investigated and Closed	Average Number of Days for Completion of Investigation	Number of UI investigations exceeding 60 Days
1998	17	17	51	6
1999	15	15	39	5
2000	41	27	65	10
Total	73	59	52	21

Source: Department of Health's Licensing and Regulation Administration

It should be noted that on average it took LRA in excess of 60 days to investigate and close 36% of all UIs reported during the review period. The Auditor has examined UI case documentation of alleged abuse that has taken LRA in excess of six months to fully investigate and close. LRA officials attributed the excessive length of time to fully investigate and close these cases to a lack of funding for additional staff.

3. LRA is not following its own procedures in responding to UIs reported by outside agencies. Pursuant to LRA policies, HFD is to send a report of pertinent findings to the referral source within a reasonable time period, preferably within 10 working days. The Auditor examined documentation of a complaint against two facilities which was submitted to LRA on February 28, 2000, by University Legal Services (ULS), the agency which provides legal protection and advocacy for persons with mental retardation or developmental disabilities in the District of Columbia. The allegations in this complaint included, but were not limited to, inadequate food, improper medical attention provided to clients, improper body checks of clients, and improper temperatures in the facilities. These allegations were documented by ULS representatives during their own independent surveys of these facilities. LRA did not initiate an investigation until March 6, 2000, and failed to submit their findings to ULS until July 5, 2000, even though they concluded their investigation on April 12, 2000. LRA did not submit their findings until ULS requested these findings again on June 12, 2000, and then only provided ULS with

a partial list of requested information. It should be noted that this investigation covered two facilities operated by the same vendor. However, this vendor operates a total of nine facilities in the District of Columbia, yet LRA did not initiate investigations into health and safety practices in the other seven facilities operated by this vendor.

The Auditor found that the Mayor established the Fatality Review Committee to examine events and circumstances surrounding the deaths of residents in the District with mental retardation or developmental disabilities in an effort to reduce the number of preventable deaths. This committee had not met, as of December 2000, to assess fatalities occurring in facilities housing MRDDA clients. Notwithstanding the creation of the Fatality Review Committee, the changes in regulations, and the establishment of incident and complaint reporting policies and procedures by DOH and DHS, the Auditor found that the District of Columbia is still without an efficient and effective system for ensuring that all unusual incidents, complaints and deaths are investigated in a thorough and timely manner to ensure the health and safety of persons with mental retardation or developmental disabilities. Deficiencies continue to exist, in part, because of staffing inadequacies within MRDDA and the Department of Health's Licensing Regulation Administration. The deficiencies also continue to persist, in part, because of the lack of coordination and communication between the numerous agencies that are responsible for regulating, investigating, monitoring, and providing other services to mentally retarded and developmentally disabled persons served by MRDDA.

RECOMMENDATIONS

The Auditor recommends that:

1. Standardized policies, procedures and forms should be established for investigating unusual incidents and deaths and that these policies and procedures apply to all persons and organizations responsible for the care of individuals with mental retardation or developmental disabilities. These policies and procedures should also be established in order to better coordinate the efforts of all agencies responsible for the investigation of UIs, complaints, and deaths of MRDDA clients to ensure thorough and timely investigations.
2. A database should be funded and developed for use by all agencies responsible for investigating unusual incidents to ensure that:
 - a. that all unusual incidents are accounted for;

- b. all incidents, complaints and deaths are investigated in a timely manner;
 - c. there is a unified system for tracking unusual incidents, complaints and deaths by vendor; and
 - d. trend analysis can be conducted to detect unusual trends and patterns by facility and by provider.
3. The Directors of DOH and DHS should adequately fund additional staff for the investigation of UIs, complaints and deaths to ensure thorough and timely investigation of all UIs, complaints, and deaths of MRDDA clients.

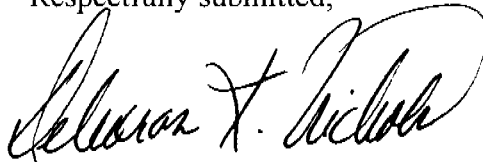
CONCLUSION

The Auditor found that specialized care facilities (adult foster homes) and specialized apartments housing MRDDA clients are not required to be licensed and they are not monitored by the Department of Health's Licensing Regulation Administration (LRA) or the Department of Consumer and Regulatory Affairs' Fire Protection Division and Building and Land Regulation Administration. Additionally, these facilities are not required to have annual fire inspections nor are they monitored for adherence to the District's building code.

The Auditor also found that LRA was not timely conducting annual inspections of intensive care facilities (ICF/MRs) and other group homes for mentally retarded persons (GHMRPs). The Auditor also discovered that MRDDA was not conducting physical inspections of facilities housing MRDDA clients outside the District of Columbia. Further, the Auditor found that annual fire inspections were not being conducted in a timely manner nor were they being conducted in accordance with District Law.

In reviewing LRA's and MRDDA's monitoring reports, the Auditor found that the process of monitoring and regulating ICF/MRs and GHMRPs needs substantial improvement. Additionally, this review revealed that the monitoring of care provided to MRDDA clients continues to need substantial improvement. The Auditor's review also revealed that the system for reporting and investigating unusual incidents, complaints and deaths is poorly managed and is also in need of substantial improvements.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Deborah K. Nichols". The signature is fluid and cursive, with a large loop at the end.

Deborah K. Nichols

District of Columbia Auditor

ATTACHMENTS

MRDDA GHMRPs and ICF/MRs
By Ward

Ward	Number of ICF/MRs and GHMRPs	Total Number of Available Beds
1	15	89
2	5	36
3	13	72
4	53	349
5	19	105
6	14	84
7	36	230
8	10	71
Total	165	1,036

Source: Department of Health, Licensing Regulation Administration

Individual GHMRPs and ICF/MRS Operating in the
District Of Columbia

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
BWT Services, Inc	1	1020 Park RD NW	G & BH Washington	Same as facility address	4	GHMRP
Community of the Arc, Inc.	1	1724 Euclid St NW	Belkacem Baccouche, ETAL	3900 Tunlaw Rd NW	4	GHMRP
Community of the Arc, Inc.	1	2474 Ontario Rd NW	Community of the Arc, Inc.	Same as facility address	6	GHMRP
Robert Swann Pittman	1	3214 14 th St NE	Body of Christ Farm Community	P.O. Box 410 Waldorf, MD	4	GHMRP
LMI, Inc.	4	815 Floral Pl NW	Lease All Corp	2819 Spriggs Request Rd Mitchellville, MD	4	GHMRP
Community Multi-Services, Inc.	4	825 Fern Pl NW	Michael & Murray McLean	Same as facility address	4	GHMRP
Community Multi-Services, Inc.	4	815 Floral Pl NW	Community Multi-Services	11314 Wycombe Park Lane, Glen Dale, MD	4	GHMRP
Community Multi-Services, Inc.	4	114 Ingraham St NW	David & Phylliss Ball	Same	4	GHMRP
D.C. Community Services	4	245 Oglethorpe St NW	AD & SJ Stubbs	1627 K St NW	7	GHMRP
Lewis & Ruth Ward	4	806 Floral Pl NW	Marie Ruth Simmons	Same	4	GHMRP
LMI, Inc.	4	5016 9 th St NW	Shirley A Purvis	3705 Stoneybrook Rd, Randallstown, MD	6	GHMRP
National Children's Center	4	6809 9 th St NW	National Children's Center	6200 2 nd St NW	5	GHMRP
Multi Therapeutic Services, Inc.	4	6217 16 th St NW	Ulysses Glee, Jr	Same as facility address	4	GHMRP
National Children's Center	4	203 Sheridan St NW	Nat' Children's Center	6200 2 nd St NW	5	GHMRP

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
Ruth E. Ward/CMMS	4	4412 Georgia Ave NW	St. Charles Baptist Church	4410 Georgia Ave NW	6	GHMRP
Symbral Foundation	4	133 Hamilton St NW	Jim & Ethel Ellison	1374 Tuckerman Rd NW	4	GHMRP
Symbral Foundation	4	5122 Kansas Ave NW	Michael & M Mullings	Same as facility address	7	GHMRP
Multi Therapeutic Services, Inc.	4	1200 Tewkesbury PI NW	Bentley A Hamilton	Same as facility address	8	GHMRP
Multi Therapeutic Services, Inc.	4	255 Farragut St NW	RS & Carolyn Monroe	Same as facility address	8	GHMRP
Bethlehem House, Inc.	5	1401 Lawrence St NE	Religious Sisters of Mercy	Same as facility address	4	GHMRP
Community Multi-Service Services, Inc.	5	1608 Everts St NE	Constance Reese	11314 Wycombe Park Lane, Glen Dale, MD	4	GHMRP
Community Multi-Service, Inc.	5	302 S St NE	Lease All Corp	2819 Spriggs Request Rd, Mitchellville, MD	6	GHMRP
D.C. Arc, Inc.	5	3018 Channing St NE	E. Savannah Little	1017 P St NW #A	3	GHMRP
LMI, Ward & Ward	5	2410 Rhode Island Ave NE	Brookland UMC	2421 Lawrence St NE	5	GHMRP
National Children's Center	5	1501 Gallatin St NE	Nat' Children's Center	6200 2 nd St NW	6	GHMRP
Henry L Folrais/Patra Kidwell	6	724 15 St NE	Bankers Trust Co.	P.O. Box 35140, Louisville, KY	5	GHMRP
ASC Habilitation Services	6	1612 East Capitol St NE	Reginald L Locke, C/O Benning Station	P.O. Box 64422, Washington, DC	5	GHMRP
D.C. Community Services	6	1435 Good Hope Rd SE	D.C. Community Services	310 20 th St NE	6	GHMRP
ASC Habilitation Services	6	916 3 rd St NE	Ibrahim & Abdel Ayyad	4511 Weldon, Dr Temple Hills, MD	4	GHMRP
Sunshine Multi-Therapeutic Center	6	603 8 th St NE	Ivans & Bobbie Leflore	Same as facility address	8	GHMRP
D.C. Arc	7	2305 36 th St SE	DC Government	N/A	5	GHMRP
Multi Therapeutic Services, Inc.	7	809 49 th St NE	Multi Therapeutic Services, Inc	4201 Connecticut Ave NW	5	GHMRP
Careco	1	1447 Oak St NW #A	Phillip R Miller	1225 13 th St NW	5	ICF/MR
Careco	1	1447 Oak St NW #B	Phillip R Miller	1225 13 th St NW	6	ICF/MR
Careco, Inc. IV	1	1447 Oak St NW #C	Phillip R Miller	1225 13 th St NW	4	ICF/MR
Community Multi Services	1	3112 13 th St NW	Community Multi Services	Same as facility address	8	ICF/MR
Comprehensive Care II	1	611 Park Rd (Closed)	AV & DW Adair	Same as facility address	8	ICF/MR

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
DC Community Services	1	401 U St NW	NPF X Inc.	6125 Memorial Dr Dublin, Ohio	6	ICF/MR
DC Family Services	1	3120 16 th St NW	JBK Corp	155 Linden Dr Basking Ridge, NJ	8	ICF/MR
DC Family Services	1	1811-15 Ontario PL NW	JM Korn & J Friedlander	155 Linden Dr Basking Ridge, NJ	6	ICF/MR
DC Family Services	1	1435 Euclid St NW	Molly Three LLC	912 Thayer Ave #105, Silver Spring, MD	7	ICF/MR
DC Family Services	1	1849 Calvert St NW	JBK Corp	155 Linden Dr Basking Ridge, NJ	7	ICF/MR
RCM of Washington	1	3117 11 th St NW	3117 11th St NW Association	700 Constitution Ave NE	6	ICF/MR
Careco (5 th Floor)	2	1225 13 th St NW	Careco, Inc.	Same as facility address	8	ICF/MR
Careco (3 rd Floor)	2	1225 13 th St NW	Careco, Inc.	Same as facility address	8	ICF/MR
DC Health Care, Inc.	2	414 N St NW	W Cheng & S Wong	Same as facility address	8	ICF/MR
DC Health Care, Inc.	2	426 Q St NW	Dandor LTD Partnership	7407 Ridgewood Ave, Chevy Chase, MD	8	ICF/MR
Wholistic Habilitative Services	2	1601 8 th St NW	Abdall Am Al-Abduilla	1301 20 th St NW #110	4	ICF/MR
Community Multi Services	3	3815 Albermarle St NW	Hollis E & CA Reese	11314 Wycombe Park Lane, Glen Dale, MD	8	ICF/MR
DC Family Services	3	4345 Wisconsin Ave NW	Jason Vogel C/O Vogel Realty	1628 R St NW #120	8	ICF/MR
Kennedy Institute	3	4815 Chesapeake St NW	Kennedy Institute Housing	801 Buchanan St NE	5	ICF/MR
Kennedy Institute	3	3010 Chestnut St NW	Dixie L Drabkin	P.O. Box 2426 Germantown, MD	6	ICF/MR
Multi Therapeutic Services	3	6014 32 nd St NW	Bently Hamilton	6014 32 nd St NW	4	ICF/MR
Multi Therapeutic Services	3	2852 Northhampton St NW	John Kim & Andrea Patterson	Same as facility address	5	ICF/MR
St. Johns Community Services	3	5518 Sherrier Pl NW	St. Johns Comm Services	4800 McArthur Blvd NW	4	ICF/MR
St. Johns Community Services	3	4434 Springdale St NW	Katherine Hall	8001 Oak Bluff Court, Montgomery Village, MD	4	ICF/MR
St. Johns Community Services	3	4835 Reservoir Rd NW	Pierre & Monique Cossard	87 La Fayette Rd Princeton, NJ	4	ICF/MR

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
St. Johns Community Services	3	5027 Fulton St NW	St. Johns Comm Services	4800 McArthur Blvd NW	4	ICF/MR
VOCA	3	4513 Butterworth PL NW	Anathanasios & M Hatzivinalis	Same as facility address	6	ICF/MR
VOCA	3	3513 Alton Pl NW	David Freyman	8720 Georgia Ave #708, Silver Spring, MD	6	ICF/MR
VOCA	3	2922 Newark St NW	Southport Realty Association	200 K St NW #3	8	ICF/MR
Associated Community Services	4	5706 14 th St NW	Robert & Mary Bradley	P.O. Box 189 Riva, MD	6	ICF/MR
Chrysalis, Inc	4	6915-17 Maple St NW	James Meginnis	807 Turnpike St, Andover, MA	6	ICF/MR
Community Multi Services	4	6300 9 th St NW	Thomas Barber	Same as facility address	6	ICF/MR
Community Multi Services	4	4314 9 th St NW	Hollis & CA Reese	11314 Wycombe Park Lane, Glen Dale, MD	8	ICF/MR
Community Multi Services	4	5610 1 st St NW	Lease All Corp	2819 Spriggs Request Rd, Mitchellville, MD	4	ICF/MR
Community Multi Services	4	703 Randolph St NW	Hollis & CA Reese	11314 Wycombe Park Lane, Glen Dale, MD	8	ICF/MR
Comprehensive Care II	4	1329 Longfellow St NW	ADSP, Inc.	711 Quackenbush St NW	6	ICF/MR
Comprehensive Care II	4	1321 Emerson St NW	ADSP, Inc.	711 Quackenbush St NW	6	ICF/MR
Comprehensive Care II	4	337 Delafield Pl NW	Benson & Margaret Harps	3700 Patterson Ave, Baltimore, MD	8	ICF/MR
DC Community Services	4	1613 Taylor St NW	James Meginnis	807 Turnpike St, Andover, MA	6	ICF/MR
DC Community Services	4	1231 Shepherd St NW	Community Facilities LTD	1701 K St NW 4 th Floor	6	ICF/MR
DC Community Services	4	210 Van Buren St NW	Thomas & LC Smith	Same as facility address	4	ICF/MR
DC Community Services	4	617 Dahlia St NW	Molly Four LLC	912 Thayer Ave #105, Silver Spring, MD	7	ICF/MR
DC Community Services	4	4901 5 th St NW	Community Facilities LTD	1701 K St NW 4 th Floor	7	ICF/MR
DC Community Services	4	39 Peabody St NW	Community Facilities LTD	1701 K St NW 4 th Floor	6	ICF/MR
DC Family Services	4	7425 8 th St NW	Encore Five LLC	912 Thayer Ave #105, Silver Spring, MD	6	ICF/MR

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
DC Family Services	4	5701 13 th St NW	Encore Three LLC	912 Thayer Ave #105, Silver Spring, MD	6	ICF/MR
DC Family Services	4	4919 N Capitol St NE	James & Earline Cobb	1718 Webster St NW	7	ICF/MR
DC Healthcare Inc	4	4601 Georgia Ave NW	Davnie & Myrna Fivel	7407 Ridgewood Ave Chevy Chase, MD	8	ICF/MR
DC ARC	4	121 Tuckerman NE	Baburan & G Stephen	5022 Warren St NW	4	ICF/MR
DC ARC	4	5101 New Hampshire Ave NW	John C Van Blake	4511 30 th St, Mt. Ranier, MD	6	ICF/MR
IDI	4	6520 1 st St NW	James Watkins Et al	Same as facility address	8	ICF/MR
Marjul Homes	4	4910 Arkansas Ave NW	J Townson & M Gahagan	160 Bryant St NW	6	ICF/MR
Marjul Homes	4	6634 Eastern Ave NW	Mark L Veney	Same as facility address	6	ICF/MR
Metro Homes	4	1433 Northgate Rd NW	A Amir Al-Abdulla	1301 20 th St NW #110	6	ICF/MR
Metro Homes	4	2268 Sudbury Rd NW	Maxwell Asenso	11200 Lockwood Dr, Silver Spring, MD	6	ICF/MR
Multi Therapeutic Services	4	1403 Whittier St NW	CP & Thomas Jackson, Jr.	1912 Tulip Circle NNW	4	ICF/MR
National Children's Center	4	6200 2 nd St NW	Nat' Children's Center	Same as facility address	45	ICF/MR
National Children's Center	4	200 Rittenhouse St NW	Nat' Children's Center	6200 2 nd St NW	5	ICF/MR
St. Johns Community Services	4	1508 Portal Drive NW	Mildred Stepda Trustee C/O Steven Fanaroff	P.O. Box 1432, Rockville, MD	4	ICF/MR
Symbral Foundation	4	7533 12 th St NW	James & Carl McGinnis	807 Turnpike St, Andover, MA	6	ICF/MR
Symbral Foundation	4	7416 Blair Road NW	Raymond & Mable Hawkins	5501 1 st St NE	4	ICF/MR
VOCA	4	7419 16 th St NW	Sherry Oaks	1735 W Alex Bell Rd, Centerville, OH	8	ICF/MR
VOCA	4	2010 Yorktown Rd NW	Southport Realty Association	200 K St NW #3	6	ICF/MR
VOCA	4	1639 Roxanna Rd NW	Manford J & SL Schmidt	915 Alroi Street, Jerusalem, Israel	6	ICF/MR
VOCA	4	1419 Van Buren ST NW	David Freyman	8720 Van Buren Ave #708, Silver Spring, MD	6	ICF/MR

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
Wholistic Habilitative Services	4	6627 1 st St NW	Robert & Izara Thomas	Same as facility address	6	ICF/MR
Wholistic Habilitative Services	4	7129 7 th St NW	Alex B Kamara	6211 Winslow Ct, Fairfax Station, VA	6	ICF/MR
Community Multi Services	5	2224 Everts St NW	Mckendree Sims Brookland UMC	2471 Lawrence St NE	4	ICF/MR
Comprehensive Care II	5	1000 Newton St NE	Dennis L & B King	1805 Robert Lewis Ave, Upper Marlboro, MD	4	ICF/MR
Comprehensive Care II	5	3605 10 th St NE	R Buckley	3600 10 th St NE	4	ICF/MR
DC Community Services	5	1004 Urell Pl NE	James McGinnis	807 Turnpike St, Andover, MA	6	ICF/MR
DC Healthcare Inc	5	47 Quiney Pl NW	Daniel & Myrna Fivel	710 A St SE	8	ICF/MR
DC Healthcare Inc	5	1938 1 st St NW	Secretary of Veteran Affairs	210 E Redwood St, Baltimore, MD	8	ICF/MR
IDI	5	2620 24 th St NE	Louis Bojan	1339 Pennsylvania Ave, SE	8	ICF/MR
St. Johns Community Services	5	2715 13 th St NE	St. Johns Comm Services	4800 McArthur Blvd NW	4	ICF/MR
Symbral Foundation	5	521 Kennedy St NE	Hymen & Lee Alpert	8555 16 th St, Silver Spring, MD	5	ICF/MR
VOCA	5	3073 Vista St NE	Molly Two LLC	912 Thayer Ave #105, Silver Spring, MD	7	ICF/MR
Westview	5	3200 12 th St NE	Fred & Dorothy West	Same	8	ICF/MR
Wholistic Habilitative Services	5	1814 Bunker Hill Rd NE	Alex Bai Kamara	C/O Ahoui E Kponou, 6 Ambel Rd, Rocky Point, NY	6	ICF/MR
Wholistic Habilitative Services	5	1314 Perry St NE	Robert & Izara Thomas	Same as facility address	5	ICF/MR
Community Alliances	6	1342 Constitution Ave NE	Peter C Eun & Ju Shin	8014 Cypress Grove Lane NW	6	ICF/MR
Comprehensive Care II	6	2001 I St NE	Alvis & Delores Adair	711 Quackenbush St NW	6	ICF/MR
DC Community Services	6	1713 Bay St SE	Memorial Drive Office Complex LLC	6035 Memorial Drive, Dublin, OH	4	ICF/MR
DC Healthcare Inc	6	901 14 th St SE	DC Government	1133 North Capitol St NE	8	ICF/MR
DC Healthcare Inc	6	1026 8 th St NE	DC Government	1133 North Capitol St NE	8	ICF/MR
Multi Therapeutic Services	6	1523 Good Hope Rd SE	NPF X, Inc.	6125 Memorial Dr, Dublin, OH	6	ICF/MR
RCM	6	1428 Independence Ave SE	Peter Shin & Sue Viltas	700 Constitution Ave NE	6	ICF/MR
Symbral Foundation	6	722 L St NE	A Amir Al-Abdulla	1301 20 th St NW #110	6	ICF/MR

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
Wholistic Habilitative Services	6	1226 Lawrence St NE	Robert & Izara Thomas	6211 Winslow Ct, Fairfax, VA	6	ICF/MR
Associated Community Services	7	5000 East Capitol St NE	Robert Bradley	P.O. Box 189, Riva, MD	5	ICF/MR
Behavioral Research Associates	7	5051 Lee St NE	Andrew & Ann Gordon	P.O. Box 492110, Ft Washington, MD	5	ICF/MR
Behavioral Research Associates	7	4288 1/2 Southern Ave SE	Andrew & AK Gordon	P.O. Box 492110, Ft Washington, MD	6	ICF/MR
Behavioral Research Associates	7	4629 NHB Ave NE	Andrew & AK Gordon	P.O. Box 492110, Ft Washington, MD	6	ICF/MR
Behavioral Research Associates	7	1034 Burns St SE	Andrew & Ann Gordon	P.O. Box 492110, Ft Washington, MD	6	ICF/MR
Comprehensive Care II	7	1100 42 nd St NE	Theresa Jessup	Same as facility address	6	ICF/MR
DC Community Services	7	3341 Massachusetts Ave SE	James McGinnis	807 Turnpike St, Andover, MA	8	ICF/MR
DC Community Services	7	4501 Grant St NE	W & D LLC	405 Blair Rd, Vienna, VA	8	ICF/MR
DC Family Services	7	3259 O St SE	Encore 2 LLC	912 Thayer Ave #105, Silver Spring, MD	4	ICF/MR
DC Family Services	7	4414-16 Jay St NE	James & Joann Artiss	12201 Dully Staten Rd, Upper Marlboro, MD	8	ICF/MR
DC Family Services	7	315 58 th St NE	Sheila Gaither	1401 Baytree Terrace NE	8	ICF/MR
DC Family Services	7	1307 45 th Pl SE	David English	4029 Glenrose St, Kennesaw, MD	4	ICF/MR
DC Family Services	7	114 Division Ave NE	Division Ave, Inc.	912 Thayer Ave #105, Silver Spring, MD	6	ICF/MR
DC ARC	7	3000 Alabama Ave SE	Joan C Vanblake	4511 30 th St, Mt Ranier, MD	4	ICF/MR
IDI	7	4515 Edson Pl NE	We Care Project C/O VOCA DC	200 K St NW #1	8	ICF/MR
IDI	7	4954 Astor Pl SE	We Care Project C/O VOCA DC	200 K St NW #1	8	ICF/MR
IDI	7	431 53 rd St SE	We Care Project C/O VOCA DC	200 K St NW #1	8	ICF/MR
Multi Therapeutic Services	7	927 55 th St NE	Maxwell Asenso & Ekua Quatey	Same	6	ICF/MR
Multi Therapeutic Services	7	6023 Clay St NE	Eddie Savannah Lowery	3204 Walnut St NE	6	ICF/MR
Multi Therapeutic Services	7	1044 45 th St NE	Dept of Housing & Urban Dev	820 I St NE	5	ICF/MR

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
RCM	7	1131 45 th Pl SE	James Pendergraft IV	P.O. Box 118, Lanham, MD	6	ICF/MR
RCM	7	1326 45 th Pl NE	Gaben Mngt Inc.	P.O. Box 8204, Silver Spring, MD	6	ICF/MR
VOCA	7	2510 R St SE	Sterling Concepts C/O VOCA DC	200 K St NW #3	6	ICF/MR
VOCA	7	4308 E St SE	Sterling Concepts, C/O VOCA DC	200 K St NW #3	8	ICF/MR
VOCA	7	5310 C St SE	Sterling Concepts, C/O VOCA DC	200 K St NW #3	6	ICF/MR
VOCA	7	325 50 th St SE	U.S. Government		6	ICF/MR
VOCA	7	401 56 th St SE	Sterling Concepts, C/O VOCA DC	200 K St NW #3	6	ICF/MR
VOCA	7	6010 Dix St NE	Sterling Concepts, C/O VOCA DC	200 K St NW #3	8	ICF/MR
VOCA	7	4012 Lee St NE	Southport Realty Associates	200 K St NW #3	6	ICF/MR
VOCA	7	615 55 th St NE	Southport Realty Associates	200 K St NW #3	8	ICF/MR
VOCA	7	505 1/2 7 th St NE	Southport Realty Associates	200 K St NW #3	8	ICF/MR
VOCA	7	2200 32 nd Pl SE	David Freyman	8720 GA Ave #708, Silver Spring, MD	7	ICF/MR
VOCA	7	3056 Q St SE	David Freyman	8720 GA Ave #708, Silver Spring, MD	6	ICF/MR
VOCA	7	2609 Branch Ave SE	David Freyman	8720 GA Ave #708, Silver Spring, MD	8	ICF/MR
Associated Community Services	8	3937 MLK Ave SW	Robert & Mary Bradley	P.O. Box 189 Riva, MD	6	ICF/MR
IDI	8	3020 Stanton Rd SE	We Care Project C/O VOCA DC	200 K St NW #1	8	ICF/MR
IDI	8	1230 Congress St SE	We Care Project C/O VOCA DC	200 K St NW #1	8	ICF/MR
IDI	8	3312 4 th St SE	We Care Project C/O VOCA DC	200 K St NW #1	8	ICF/MR
VOCA	8	2820 Hartford St SE	Sterling Concepts C/O VOCA DC	200 K St NW #3	8	ICF/MR
VOCA	8	639 Atlantic St SE	Sterling Concepts C/O VOCA DC	200 K St NW #3	6	ICF/MR

Provider	Ward	Facility Address	Property Owner	Property Owner's Mailing Address	Beds	Type of Facility
VOCA	8	2441 Elvans Rd SE	Sterling Concepts C/O VOCA DC	200 K St NW #3	8	ICF/MR
VOCA	8	3765 1 st St SE	Sterling Concepts C/O VOCA DC	200 K St NW #3	8	ICF/MR
VOCA	8	#3 DC Village Lane SW	Sterling Concepts C/O VOCA DC	200 K St NW #3	5	ICF/MR
VOCA	8	199 Chesapeake St SW	DC Government	1133 North Capitol St NE	6	ICF/MR
TOTAL					1,036	

Source: Department of Health, Licensing Regulation Administration, District of Columbia Office of Tax and Revenue

AGENCY COMMENTS

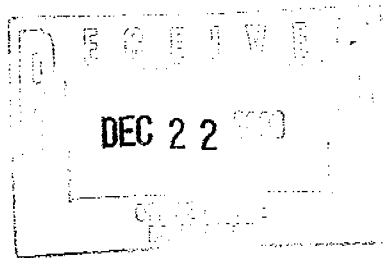
AGENCY COMMENTS

On December 8, 2000, the Office of the District of Columbia Auditor submitted a draft report for review and comment to the following agencies and offices: the Department of Consumer and Regulatory Affairs; the Department of Human Services; the Department of Health; the Licensing Regulation Administration of the Department of Health; the Medical Assistance Administration of the Department of Health; the District of Columbia Fire Marshal; the District of Columbia Long Term Care Ombudsman; the District of Columbia Chief Medical Examiner; the Mental Retardation and Developmental Disabilities Administration; and the Office of the Corporation Counsel.

Combined written comments were received from the Department of Health; the Department of Human Services; and the Mental Retardation and Developmental Disabilities Administration. Additionally, written comments were received from the District of Columbia Fire Marshal, the District of Columbia Long Term Care Ombudsman; and the District of Columbia Chief Medical Examiner. The Department of Consumer and Regulatory Affairs and the Office of the Corporation Counsel did not provide any comments to the draft report. Where appropriate, changes to the final report were made to reflect agency comments. All written comments received by the Auditor are appended in their entirety to this report.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director



December 22, 2000

Ms. Deborah K. Nichols
District of Columbia Auditor
Office of the District of Columbia Auditor
717 14th Street, N.W., Suite 900
Washington, DC 20005

Dear Ms. Nichols:

I am writing in response to your December 8, 2000 letter requesting Department of Health review and comment of the draft report entitled "A Review of Community Residential Facilities Used by the Mental Retardation & Developmental Disabilities Administration".

At the request of the Office of Deputy Mayor Carolyn Graham, the Department of Human Services and the Department of Health will submit a joint response, which will be submitted by the Department of Human Services. The response is expected to be sent today.

If you have any questions, please call Denise Pope, Administrator of the Health Regulation Administration, at 442-4747 or me at 442-5999,

Sincerely,

A handwritten signature in cursive script that reads "Rosalind Keitt for".

Ivan C.A. Walks, M.D.
Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA

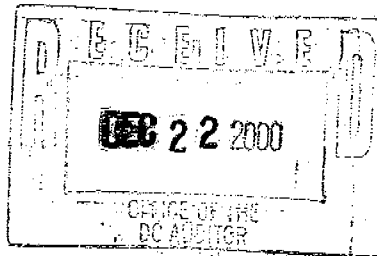
EXECUTIVE OFFICE OF THE MAYOR



CAROLYN N. GRAHAM
Deputy Mayor for Children, Youth and Families

HAND DELIVERY

December 22, 2000



Ms. Deborah K. Nichols
District of Columbia Auditor
Officer of the District of Columbia Auditor
717 14th Street, N.W., Suite 900
Washington, D.C. 20005

Dear Ms. Nichols:

The draft report entitled, "A Review of Community Residential Facilities Used by The Mental Retardation and Developmental Disabilities Administration", has been reviewed by staff at the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (MRDDA) and Office of Investigations and Compliance (OIC), as well as the Department of Health, Health Regulation Administration (HRA), formerly known as the Licensing Regulation Administration (LRA).

Please find attached the consolidated official response from the Department of Human Services for inclusion in the D.C. Auditor's final report. Also attached is a copy of the revised Incident Management Policy and Procedures, referred to in the response.

If further detail or explanation is needed regarding comments in this response, please telephone me at 727-8001.

Sincerely,

Carolyn N. Graham
Deputy Mayor for Children, Youth and Families

CNG/egp

Attachments

District's Response to
D.C. Auditor's Report - Dec. 8, 2000

CNG/egp
12/20/00

441 4th Street, N.W., Washington, DC 20001

Consolidated Response to Findings and Recommendations Contained in the Draft Report, "A Review of Community Residential Facilities Used by The Mental Retardation & Developmental Disabilities Administration" by the Office of the District of Columbia Auditor

This response has been categorized in the following manner: The Auditor's Findings; The District's Discussion of the Issue(s); The Auditor's Recommendations; and The District's Response to the Recommendation(s). For easier reference, each Finding has been labeled from A – F and the corresponding page numbers from the Auditor's report are indicated.

Auditor's Finding A (pg.9): SPECIALIZED HOME CARE FACILITIES (ADULT FOSTER HOMES) AND SUPERVISED APARTMENTS ARE NOT REQUIRED TO BE LICENSED

The District's Discussion of the Issue(s): While the District has no current provisions for licensing supervised apartments and specialized foster homes, the supervised apartments located in the state of Maryland are licensed by Maryland's Office of Health Quality.

Auditor's Recommendation for Finding A: The Auditor recommends that the Council consider requiring all facilities housing MRDDA clients, including adult foster homes and apartments, be licensed in order to ensure that they are: 1) regularly inspected; 2) adhering to District of Columbia health and safety regulations; and 3) that facility providers are fulfilling their fiduciary and contractual obligations to ensure the health and safety of MRDDA clients. The licensure requirement would also reveal whether these facilities are adhering to the District's building and fire codes.

The District's Response to the Recommendation(s): The District of Columbia will fully explore this recommendation. The District is committed to providing safe, adequate and properly managed facilities, and will assess the fiscal impacts of meeting this recommendation.

Auditor's Finding B (pg.10): LRA IS NOT TIMELY CONDUCTING ANNUAL INSPECTIONS OF ICF/MRs AND GHMRPs

The District's Discussion of the Issue(s): The Auditor reported testing all 132 ICF/MRs and reported finding that all facilities were adhering to Section 3102.4 by filing a license renewal application approximately 90 days prior to the expiration of their current license. The Auditor also stated that LRA failed to timely perform annual inspections and to ensure that these facilities' licenses were renewed before or at the time

their existing licenses expired. HRA disputes the figures cited in the draft report. Due to the extremely short time available for response to the report, the administration is not able to provide a case-by-case listing of all the facilities for the three years at issue. If desired, HRA would be able to provide such a report at a later time. HRA acknowledges, however, that staffing issues have historically hindered any attempts to timely inspect and certify all facilities. HRA reports that they are actively hiring and training additional staff. With the added staff complement, as well as surveyors employed on a contract basis, HRA has focused its efforts on two fronts: continuing efforts to conduct surveys of the remaining facilities in the backlog, while at the same time conducting surveys of facilities that are currently due for annual inspections.

It is noted that the federal regulations for ICF/MRs overlay additional, and frequently inconsistent timelines onto local efforts. For example, there is the expiration date of the license and the expiration of the federal certification. If the two dates are not the same, HRA has found it more expedient to focus on the certification date. According to DC law, the license remains in effect as long as no action is taken against it. Therefore, although on occasion an annual inspection may technically be done after the license expiration date, it is in fact conducted annually.

The purpose of the annual inspections as described in the draft report is not entirely accurate. The purpose of the annual inspection is to determine the group homes' continued compliance with regulatory requirements. Violations of regulations are recorded and communicated to the provider in deficiency reports; the provider then has the opportunity to take corrective action and to report to HRA the details of its corrective action plan. The plan must indicate the actions taken or scheduled within the immediate future, the completion date, the systems to be changed, and the quality assurance methodology that will ensure that will be used to ensure continued compliance.

HRA acknowledges that because of staffing limitations, surveyors have not been able to fully validate all providers' corrective actions. Monitoring efforts have been directed at those situations that have the most serious allegations concerning resident care. It is anticipated that through improved collaboration between HRA and MRDDA, monitoring group homes will occur with greater frequency. With this increased monitoring, and with the resultant increase in enforcement actions (fines, Medicaid termination, and licensure suspension/revocation), it is anticipated that providers will recognize that the District of Columbia takes very seriously its responsibility of ensuring the health and safety of persons with disabilities. It is firmly believed that the provider community will soon realize that compliance is ultimately less costly than noncompliance.

Further, the Auditor appears to interpret D.C. Law 12-86, Title 5, Sections 501 and 502, to give responsibility for conducting annual fire inspections for all licensed facilities to the Department of Consumer and Regulatory Affairs (DCRA). The DCRA, Building and Land Regulation Administration has the responsibility of conducting inspections and of issuing Certificates of Occupancy. After a Certificate of Occupancy is issued, the responsibility for conducting inspections is delegated to the District of Columbia Fire

Department, Fire Prevention Bureau. Licenses for GHMRPs are issued by the Department of Health, Health Regulation Administration.

Auditor's Recommendations for Finding B (pg. 15):

The Auditor recommends that:

1. The Director of DOH provide LRA with sufficient resources, specifically to increase staffing levels for facility inspectors to ensure that health and environmental inspections are conducted prior to license expiration.
2. DCRA immediately conduct annual fire inspections of all ICF/MRs and GHMRPs in accordance with D.C. Law 12-86.
3. The Council of the District of Columbia should consider enacting legislation requiring the Fire Marshal of the District of Columbia to conduct annual fire inspections of all facilities housing mentally retarded and developmentally disabled clients served by the District of Columbia.
4. LRA should ensure that the agency conducting annual fire inspections of ICF/MRs and GHMRPs are conducting the inspections in a timely manner.

The District's Responses to the Recommendations:

1. The Health Regulation Administration is in the process of actively recruiting, hiring and training additional surveyors.
2. and 4. Fire inspections for ICF/MRs and GHMRPs are conducted by the Fire Department. The applicable federal regulations require that a federally certified inspector conduct the fire inspections in any facility receiving federal funds. There are two fire inspectors in the District of Columbia. These inspectors have conducted inspections on an annual basis, as required by the regulations. Thus, mentally retarded and developmentally disabled residents in these facilities are not at great risk from fire hazards. Moreover, it is HRA's understanding that, although DC Law 12-86 did exclude the DC Fire Department, Fire Prevention Division from the Certificate of Occupancy inspection, it did not remove the responsibility for determining continuing compliance with the DC Fire Code from that office.

Auditor's Finding C (pg. 15):

THE PROCESS OF MONITORING AND REGULATING ICF/MRs AND GHMRPs NEEDS SUBSTANTIAL IMPROVEMENT

The District's Discussion of the Issue(s): Please refer to the District's Responses to Recommendations for Finding C on pages 4 and 5.

Auditor's Recommendations for Finding C (pg. 24):

The Auditor recommends that:

1. The Director must provide sufficient resources to increase the number of LRA facility inspectors in order to ensure that follow-up visits are conducted and to timely validate the abatement of deficiencies.
2. LRA must conduct follow-up visits within 30 days of the issuance of a statement of deficiencies to determine whether the cited deficiencies have been abated.
3. MRDDA and LRA must establish a policy of sharing monitoring results. Timely sharing of such information could accelerate the process of deficiency correction in the event that deficiencies are discovered by an MRDDA case manager prior to LRA's annual site visit. LRA's providing MRDDA with LRA monitoring reports could also prevent the possible placement of a client in a facility with unabated deficiencies.
4. Periodic on-site monitoring of out-of state facilities must be reestablished to ensure the health and safety of clients residing in these facilities.
5. Providers should be required to maintain strict compliance with the criminal background check requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998 or face immediate monetary and other sanctions. Further, LRA must strictly enforce these sanctions.
6. Verification of criminal background checks should be instituted as a part of LRA's annual monitoring process.

The District's Responses to the Recommendation(s):

1. and 2. Please see Response to Finding B number 1 on page 3 of this report.
3. As a result of an interagency agreement that was developed in early 2000, copies of survey results, as well as the provider's corrective action plan, are being provided to MRDDA. The agreement between the agencies is that Case Managers will lend assistance to the providers and will conduct an analysis of the providers' correction actions. Any observed noncompliance will be reported to HRA. In addition, when HRA surveyors discover situations that could be potentially life threatening, a telephone call is made to the MRDDA Chief Case Management to ensure that all efforts are expended to bring the matter to a quick resolution. As of late 1999, weekly meetings were instituted between DOH, MRDDA and MPD to discuss ongoing investigations. Moreover, HRA reports are available for review by any District agency by request.
4. MRDDA monitors the facilities within the state of Maryland in the same manner that facilities in the District of Columbia are monitored. The District expects all out-of-state

facilities to comply with the regulations and laws of the states in which they operate. While visits did not occur at every out-of-state facility (with the exception of Maryland facilities), MRDDA did conduct several out-of-state visits in FY 2000 and in FY 2001. Beginning in year 2001, the agency is requiring that on site visits to out-of-state facilities occur at least four times a year.

5. The Unlicensed Personnel Criminal Background Checks Act of 1998 must be supported by enabling regulations before HRA can institute enforcement actions. The regulations have been published as proposed and the public comments received are currently under consideration. Once the regulations are published as final, HRA will enforce them. It is anticipated that publication will be done within the next few weeks.

6. The regulations do not require that HRA conduct monitoring visits; however, during the annual licensure renewal inspections, surveyors do review personnel files for criminal background check information, as required by law.

Auditor's Finding D (pg. 25): **THE MONITORING OF CARE PROVIDED TO CLIENTS NEEDS IMPROVEMENT**

The District's Discussion of the Issue(s): Within this section of the Auditor's report there are some significant errors, for instance:

- The statement that the case managers participate in the assessment of individual client needs is erroneous. While case managers participate in identifying customer needs, they do not conduct clinical assessments (e.g., dental, vocational, psychological, etc.) that identify needs, but they do monitor the recommendations for services contained in the IHP and report on whether these recommendations have been carried out or not. When a recommendation is not met and the individual does not receive the service that is required, then the case manager reports that as a "need" that has not been met for that individual. Within the MRDDA service community when one speaks of "assessment of individual needs", one is usually referring to evaluation tools used by professionals to determine what the needs of the individual are and reports are generated documenting these needs with recommendations concerning how to address the needs. Again, the case manager monitors whether the need is addressed within the timelines stipulated in the Individual Habilitation Plan for individuals on their caseloads.
- The information reported in the Auditor's report concerning caseloads and case manager ratios is also incorrect. Although MRDDA is moving toward reducing caseloads to the levels indicated as "best practice" by the Association for Retarded Citizens (ARC), it should be noted that MRDDA is in compliance with an existing court order that mandates a ratio of 1:60. Along the same lines the Auditors' Report errors when it reports that "as of September 30, 2000 MRDDA

was staffed with 37 case managers and had an average caseload of approximately 54 clients which exceeded the case manager to client ratio suggested by the ARC by 24 to 29 clients". Again, it should be noted that MRDDA is moving toward reducing caseloads but the time period for doing so is not one that is set by the Auditor, nor the ARC. Further, the Ratio Report for September 2000, that was submitted to the Court under the Evans Court Order, indicates that there were 33 case managers, with hires being made on September 25 (2) and September 27 (1). The ratio at that time was an average of 1:47.6. While the Auditor states that the Association for Retarded Citizens stated "in general, good practice is for each service coordinator or case manager to serve no more than 25 – 30 individuals", MRDDA, while working to reach caseloads of 1:30, is not obligated to have such caseload figures at this time.

- The Auditor's Report states that "the Pratt/Evans Consent Decree mandates MRDDA's case managers to conduct a minimum of three home visits and one day program visit each quarter for each client...". This is an erroneous statement. The Pratt/Evans Consent Decree mandates that the case manager make quarterly visits per year to the customers. The decision to visit the home or residential facility three times each year (not each quarter) and the day program once per year (not once each quarter) was made by the Administrative staff of MRDDA. The figures presented by the Auditor would indeed be overwhelming if the case manager were obligated to visit the client four times each quarter.
- The Auditor's report indicates that case managers coordinate and monitor the development of the IHP (Individual Habilitation Plan). This is currently not the case. Case managers do not monitor the development of the IHP, they participate in the development of the IHP. They assist in the coordination of IHP meetings by providing information regarding who needs to attend the meeting, the address and phone number for those persons identified and their relationship to the customer and may, in some cases, contact individuals who are difficult for others to contact. The coordinator of the meeting is either the QMRP for the ICF's or the MRDDA IHP Coordinator.
- There was an error in the Auditor's report that appears to be based on the misunderstanding of what case managers must file and which reports are required of the case manager. Case managers only write court reports on those customers who are committed to the District of Columbia through the MR Court. No case manager for MRDDA has a caseload only of individuals who are known to the court. Status reports are written to address concerns of the court issued to MRDDA in Court Orders. On the average, a case manager may write six court reports in a month and six to eight status reports in a year. Neither of these figures is large nor do they represent an undue amount of work to be completed by the case manager. Case managers do not make court appearances. MRDDA has Court Representatives that represent the agency at court hearings. The numbers presented in this section by the Auditor are based on erroneous information.

- It is unclear to MRDDA to what “report” the Auditor is referring when the report states “the resulting report filed with the court quarterly” (pg. 27). MRDDA files a report with the court quarterly regarding the case manager to customer ratios and every six months a report on the needs of the Evans class members is filed, but case managers are not specifically responsible for filing either of these reports.
- The salaries offered by MRDDA to its case managers are competitive with what is being offered by the governments and private sector in the Metropolitan area. A recent visit by the management staff of MRDDA to Fairfax County’s program confirmed that the salaries offered by MRDDA are indeed competitive with what is being offered there. The statement included here concerning the level of work is flawed because of the incorrect information upon which the Auditor based his conclusions concerning what is required of the case manager.
- The Auditor erroneously states that “prior to fiscal year 2000, MRDDA case managers were required to have a masters degree in a social science and 2 to 3 years of experience working with persons with mental retardation or developmental disabilities.” The recruitment advertisements issued by the Office of Personnel do not indicate a requirement that case managers be solely required to have a master’s degree and 2 to 3 years of experience. The Position Vacancy Announcement for the case management coordinator position, has consistently indicated the educational requirement for the position and also indicates that persons with a bachelors degree may apply with the years of specialized experience in and/or educational coursework for applying for the position. Therefore, MRDDA has not lowered its standard in recruiting for case managers. It is an assumption, based on incorrect information, that MRDDA runs the risk of assigning MRDDA clients to case managers who may not have the educational background necessary to adequately serve persons with mental retardation or developmental disabilities. While education is one of the factors to be considered in hiring persons to work as case managers, it alone does not make a person a success at serving and working with persons with mental retardation and/or developmental disabilities. It is true that many of the case managers do have masters degrees, however, there are others who have worked as case managers for a number of years who do not have masters degrees.

Auditor’s Recommendations for Finding D (pg. 28):

The Auditor recommends that:

1. The Director of DHS increase funding to hire more case managers, thereby reducing the case manager to client ration and improving MRDDA’s effectiveness in serving its clients. This funding should also include a means to attract persons with the highest level of education and experience possible.

2. The Administrator of MRDDA should require and afford case managers the opportunity for continuing education in order to remain current with state-of-the-art approaches in the treatment and care of persons with mental retardation or developmental disabilities.

The District's Response to the Recommendation(s):

1. The District of Columbia government has made a commitment to reduce the caseloads of the case managers at MRDDA to 1:30. MRDDA is on track to meet this goal prior to the December 31 deadline. Since September 2000 MRDDA has hired eleven new case managers. The ratio is presently 1:33.2 and the expectation is that enough qualified case managers will have been contracted for by the end of 2000 so that the caseload ratio will be 1:30. MRDDA continues to make efforts to attract and hire persons with the highest level of education and experience possible and will, within reasonable limits, continue to make every effort to hire and retain these individuals. Case managers are required to possess at least a Bachelors degree and one year experience at the next lower grade level, or two years specialized experience in the field of mental retardation. Further, funding is adequate to attract quality professionals, for the salaries offered by MRDDA to its case managers are competitive with what is being offered by the governments and private sector in the Metropolitan area.
2. It has always been the posture of the Administrator of MRDDA, both past and present, to encourage and offer staff the opportunity to take continuing education courses in order for staff to remain current with state of the art approaches in the treatment and care of persons with mental retardation or developmental disabilities. In an effort to address the training issues and continuing education credit, MRDDA is actively engaged in writing a proposal with the University of the District of Columbia to offer certification courses not only to MRDDA staff but to the staff of the provider community as well. When completed this curriculum will address many of the educational concerns that have been expressed not only by the Auditor but also by MRDDA staff, the advocacy and oversight community and the provider community as well. MRDDA is currently drafting a training policy, which will require specific pre-service and in-service training for all MRDDA staff in the areas of customer care and operational issues. In addition, professional staff will be required to remain current with state-of-the-art approaches to treatment through both in-service and continuing education courses. Funding has been provided in the FY 2001 budget for staff training to meet these requirements. In service training has been ongoing since February 2000, in the areas of incident management, normalization and community inclusion, safety issues, etc.

Auditor's Finding E (pg.29): **SYSTEM FOR REPORTING UNUSUAL INCIDENTS, COMPLAINTS AND DEATHS IS POORLY MANAGED**

The District's Discussion of the Issue(s): The District is in the process of instituting a revised Incident Management policy and procedure that further refines the requirements of the December 1999 Incident Management policies. The updated 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. As 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.

Auditor's Recommendations for Finding E (pg. 35):

1. Standardized policies, procedures and forms be established for the reporting of usual incidents and deaths and that the policies and procedures apply to all persons responsible for the care of persons with mental retardation or developmental disabilities.
2. Existing rules and policies for the reporting of deaths be reconciled with standardized policies and procedures.
3. A database should be funded and developed for use by all agencies responsible for reporting any unusual incidents to ensure that:
 - a. all unusual incidents are accounted for;
 - b. there is a unified system for tracking incidents, complaints and deaths by vendor;
 - c. all incidents, complaints and deaths are investigated in a thorough and timely manner; and
 - d. trend analysis can be conducted to detect unusual trends and patterns by facility and by provider.

The District's Response to the Recommendation(s):

1. On September 28, 2000, the District instituted a revised Incident Management policy and procedure that further refines the requirements of the December 1999 policies. This newly revised policy reflects a comprehensive set of standards for identifying incidents, reporting of incidents, investigation of serious reportable incidents per the policy, and quality improvement functions for both providers and District government agencies. [See attached policy for further reference].

With the exception of customers living in their natural home (where compliance with the Incident Management policy is voluntary), all entities that provide services to MRDDA customers (residential, day programming, transportation, individual contractors, foster care providers, etc.) are required to abide by the guidelines set forth in the Incident Management policy. The policy does not distinguish between those providers who are

licensed by DOH and those who are located in other jurisdictions or are not required to be licensed based on the number of customers housed in their home.

All providers received copies of the December 1999 policy and received training in February 2000. The revised policy was distributed to all providers in October 2000 and training on the revised policy began during the week of December 11 – 15, 2000, with over 150 provider staff receiving training during this period. Another training session is scheduled for January 2001. Further, “train-the-trainers” sessions will be held in January 2001 to increase the number trainers qualified to provide this training to MRDDA and provider staff.

Future training will involve various modules pertaining to:

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

A plan has also been developed that will address the necessary time frames for implementing the delivery of training related to incident management issues. It will 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 investigative 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.

2. The existing policy relative to reporting deaths is the standardized policy. Since December 1999, there have been standardized policies and procedures for the reporting of deaths of MRDDA customers. This policy was revised and reissued in September 2000. All deaths are to be reported immediately by provider staff to the Metropolitan Police Department and the Office of the Chief Medical Examiner. Additionally, once a death is reported to MRDDA, written notification (via fax) is forwarded to the Special Investigations Unit at MPD, the Medical Examiner’s central fax number and General Counsel, the Department of Health (HRA and MAA), the Pratt Monitor (for Pratt class members), the DHS Office of Investigations and Compliance, the Special Master, plaintiffs’ attorneys and other governmental agencies as appropriate. Appropriate documentation is maintained to verify the notification of all entities.

3. A database has been developed for the tracking of unusual incidents. At present, this system can provide data on the number of incident reports received by MRDDA, name of customer(s)/staff involved, name of provider where incident occurred, and type of incident. A weekly report is generated which details those reports entered into the database that week by customer name, provider name, type of incident, etc. Special runs can also be done to list incidents by provider, by customer, by incident type, or by date.

While there presently is a manual system that tracks where incidents are forwarded for review, further refinement to the database is underway that will automate this process to include cross agency tracking ongoing investigations and dispositions.

Auditor's Finding F (pg. 36): **INVESTIGATIONS OF UNUSUAL INCIDENTS, COMPLAINTS AND DEATHS ARE INADEQUATE.**

The District's Discussion of the Issue(s): The Auditor reports that "the District, in its failure to timely investigate and resolve these incidents, is placing mentally retarded and developmentally disabled persons' lives in serious danger by possibly having them remain in a situation of abuse and neglect". Statements such as tend to produce alarm. Therefore, care should be taken to present facts and data as they relate to these types of statements. As a result of the revised incident management policy, MRDDA follows the procedures of distributing to other necessary agencies the incident reports in accordance with the new incident management policy. Case managers follow-up on all incidents by monitoring the health and safety issues denoted in the report, within 24 hours of notification of the incident.

Serious reportable incidents are referred to OIC for investigation. Upon receipt of the incident report, OIC reviews the report and within 24 hours makes a determination of potential risk of further harm, and makes contact with the involved parties to assess whether the customer is removed from the situation, where further harm can occur. A full investigation begins within 72 hours of receipt of the incident report. Following these procedures should decrease the possibility of persons remaining in situations of abuse and/or neglect.

Auditor's Recommendations for Finding F (pg. 44):

1. Standardized policies, procedures and forms be established for the reporting of usual incidents and deaths and that the policies and procedures apply to all persons responsible for the care of persons with mental retardation or developmental disabilities. These policies and procedures should also be established in order to better coordinate the efforts of all agencies responsible for the investigation of UIs, complaints, and deaths of MRDDA clients to ensure thorough and timely investigations.

2. A database should be funded and developed for use by all agencies responsible for reporting any unusual incidents to ensure that:

- a. all unusual incidents are accounted for;
- b. there is a unified system for tracking incidents, complaints and deaths by vendor;
- c. all incidents, complaints and deaths are investigated in a thorough and timely manner; and
- d. trend analysis can be conducted to detect unusual trends and patterns by facility and by provider.

3. The Directors of DOH and DHS should adequately fund additional staffing for agencies responsible for the investigation of UIs, complaints and deaths to ensure thorough and timely investigation of UIs, complaints, and deaths of MRDDA clients.

The District's Response to the Recommendation(s):

1. As previously stated MRDDA's Incident Management policy was revised on September 28, 2000 and is being implemented by provider and agency staff. Inherent in the policy are procedures for contractors and provider agencies and procedures that address reporting of incidents to and coordination among the investigative agencies such as the Metropolitan Police Department (MPD), the Office of the Medical Examiner (OME), Department of Health (DOH), and the Office of Investigation and Compliance (OIC).
2. See response to Recommendation E3.
3. The Department of Human Service has funded two full-time Investigator Review positions in OIC. These individuals have a combination 21 years of legal, practical, administrative experience in working with the developmentally disabled population. These staff are dedicated to specifically investigating serious reportable incidents affecting MRDDA customers. Additionally, staff at MRDDA will be trained to perform routine investigations. All customer deaths will also be reviewed by the Fatality Review Committee chaired by the Chief Medical Examiner.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT
WASHINGTON, D.C. 20001

FILE

★ ★ ★



December 19, 2000

Ms. Deborah K. Nichols
District of Columbia Auditor
717-14th Street, N.W., Suite 900
Washington, D.C. 20005

Dear Ms. Nichols:

In response for comments on the draft report entitled "A Review of Community Residential Facilities used by The Mental Retardation and Developmental Disabilities Administration," the following is submitted.

Please see a copy of a memorandum submitted by the Fire Inspector-Technicians in regards to the Annual Fire Inspections and how and when they are conducted.

A Memorandum of Agreement between the Department of Consumer and Regulatory Affairs and the Fire and Emergency Medical Services Department has been completed and was signed by both agency heads on September 15, 2000.

~~On page 55 under Recommendations, Item 3(a); please make the language as specific as possible to include the reporting of any unusual instances of fire or request for emergency medical services within a facility or on the property thereof.~~

If you have any questions, I may be reached at 727-3659.

Sincerely,

Adrian H. Thompson
Fire Marshal

Enclosures

Memorandum

Government of the District of Columbia

TO: Adrian Thompson
Fire Marshal

Department, Fire
Agency, Office: FPB

FROM: Brenda J. Fenton
Joseph G. Madison *JGM*
Fire Inspector Technician

Date: December 12, 2000

SUBJECT: ICF/MR Inspections

In response to your request for information on the Intermediate Care Facilities for the Mentally Retarded, the following is submitted:

One of the main rules we are required to follow is the State Operations Manual, (US Department of Health, Health Care Finance Administration); Section 2700(C), which states in part, "Schedule LSC surveys to coincide with the health survey. In no instance should the LSC survey precede the health survey, Therefore, our surveys/inspections are dictated by the Health Department survey schedules and initiation of surveys. If our inspections are behind it is because we must wait for the Department of Health Surveyors, who are behind. Our understanding is that [they] Department of Health are several months behind. The Department of Health's solution has been to hire five (5) new Surveyors; which brings the total of DOH surveys to more than 30 Surveyors. This is comparatively less than the total two (2) Healthcare Inspectors for Fire Prevention Bureau.

Healthcare facilities required to be surveyed in this jurisdiction are ICF/MRs, Hospitals, Nursing homes, Renal Dialysis Centers, and Ambulatory Surgical Centers. Each of these facilities require a federal packet, consisting of minimum of fifteen pages, plus time sheets, Crucial Data Sheets, rating forms and FSES forms. These must be computer generated with a computer and program not provided by the Fire Department.

In summary, there will be fluctuations in the average number of inspections performed and generally it will be mandated by the Department of Health work schedule.

12-12-00
ROTED:
[Signature]
FIRE MARSHAL



Legal Counsel for the Elderly
 Office of the District of Columbia
 Long-Term Care Ombudsman
 601 E Street, N.W.
 Washington, DC 20049
 (202) 662-4933 (voice)
 (202) 434-6562 (TDD)



DISTRICT OF COLUMBIA OFFICE ON AGING

December 21, 2000

Deborah K. Nichols
 District of Columbia Auditor
 717 14th Street, NW, Suite 900
 Washington, DC 20005

Re: Comments Regarding ICF/MR Report by
 The Office of the District of Columbia Auditor

Dear Ms. Nichols:

The Long Term Care Ombudsman program found your ICF/MR draft report, the objectives and recommendations, to be very accurate. Even though the Board and Care ombudsman does not monitor ICF/MRs, the data was compared to Community Residential Facilities (CRFs and MHCRFs) regulated under DCMR Title 22, Chapters 34 and 38. When this data was cross referenced, the ombudsman found several similarities which included: LRA failing to ensure ~~that deficiencies were abated, fire inspections and house insurance not updated by the provider or~~ DCRA, insufficient numbers of inspectors compared to workload, clientele risk due to lack of monitoring. These are just a few of our examples (data comparisons) that support your drafted report.

The Ombudsman Program did notice that the DC Department of Health Services, Adult Protection Services (APS), was not mentioned in this report. We believe the APS monitors would be a valued asset to your investigation, for they also handle complaints and monitor ICF/MR facilities. The Acting Director for APS is Richardo Lyles; Mr. Lyles should be contacted for his views and concerns regarding your objectives and the responsibilities the DC government has when monitoring and supporting ICF/MR programs.

The information provided in your report is supported by the DC OIG report that was distributed to the public on October 26th, 2000. With these reports now in circulation, and both reflecting recommendations of how this decaying system should function, your final report should reflect

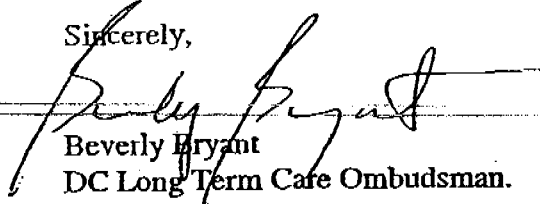
the next stages of change for MRDDA and the DOH, LRA. The report should give the reader answers to some tough questions relating to but not limited to the following:


1. Who or what agency should be responsible for creating "Phase 2" of development standards, implementation of training new surveyors, and measurement tools for MRDDA and DOH?
2. What agencies should be included on a committee to oversee daily operations and renovations of the management tools?
3. Who or what agencies should be notified to assist DOH, DCRA, and LRA for employment recruitment of surveyors?
4. Who would be the best person(s) to set up an employee retention program with the limited resources offered by MRDDA and DOH?

To ensure your findings are put to good use, the Ombudsman program believes these questions should be addressed to the City Council Members and the Mayor's Office. The City Council Members and the Mayor's Office can assist with the implementation phase, financial controls of agencies' budgets, and research other state programs to assist DC to change its own system. This would be advantageous if the implementation proceedings would be conducted in an open forum with all agencies involved to hear their inputs on how this information can be utilized to its best potential.

Thank you for letting the Long Term Care Ombudsman program comment on the ICF/MR drafted report. Hopefully our comments above are useful for your objectives. If you have any questions, please feel free to call my office (202) 434-2140, or Gerald Kasunic, Ombudsman for Board and Care at (202) 434-2138.

Sincerely,


Beverly Bryant
DC Long Term Care Ombudsman.


Gerald Kasunic
Long Term Care Ombudsman

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER**

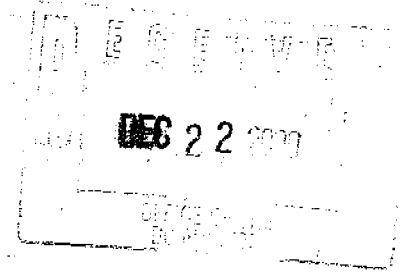
1910 Massachusetts Ave., S.E., Bldg. 27
Washington, D.C. 20003

Jonathan L. Arden, MD
Chief Medical Examiner

Telephone 202-698-9001
Fax 202-698-9101

21 December 2000

Ms. Deborah K. Nichols
District of Columbia Auditor
717 14th St. N.W., Suite 900
Washington, D.C. 20005



Dear Ms. Nichols:

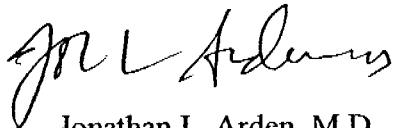
Thank you very much for providing me a copy of the draft report entitled "A Review of Community Residential Facilities Used by The Mental Retardation & Developmental Disabilities Administration". I have reviewed it, and would like to offer a few brief comments. I will confine my comments to issues regarding death investigations, which come under the jurisdiction of the Office of the Chief Medical Examiner (OCME), in contrast to other Unusual Incidents, which do not.

One area of concern expressed in this report is that deaths of MRDDA clients may not be reported routinely to the OCME, and that death investigations may not commence in a timely fashion. The jurisdiction of OCME is to investigate deaths caused by any means of violence, as well as those that occur suddenly and without explanation; however, deaths of people in the care or custody of the District government also fall within OCME jurisdiction, which includes MRDDA clients. In addition to the emergency legislation sponsored by Mrs. Allen and passed by the Council mandating autopsies on deceased wards, there is also a comprehensive new statute passed this year that establishes the OCME as a subordinate Executive Branch agency of the District government, in which the criteria for jurisdiction were clarified, including new language specifying that deaths of "wards of the District" will be investigated by OCME. The OCME policy regarding deaths of District wards is to accept jurisdiction and perform autopsies uniformly. When OCME investigates such deaths, contact is made routinely with the Metropolitan Police Department, Department of Health and MRDDA, to assure that all parties are aware of a client death. If the group home providers report client deaths to MRDDA and/or the licensing administration in DOH, those entities are now routinely referring those reports to OCME. Some of these deaths will be reported to OCME independently by the police or hospital, as well. OCME opens an investigation at the time the telephone report is received. The above factors should ensure that deaths of MRDDA clients occurring in the District will be investigated by all of the appropriate agencies in a coordinated fashion.

The other parts of the report that pertain to death investigations are on pages 32-35, and 43-44. The general theme in these sections relates to creating a database to track and analyze trends in the fatalities of MRDDA clients. In my opinion, the best mechanism to collect and collate such data is the MRDDA Fatality Review Committee. This entity is designed to bring all the involved parties together to share data, and identify trends and systemic problems affecting the MRDDA population. In recent months, I have assumed responsibility for this project, working with the MRDDA Transition Team assembled by Deputy Mayor Graham. The protocol has been revised, and a committee meeting took place on 13 December. The committee is addressing the last details of operation, and appointments are being sought for the remaining public member positions. While admittedly behind schedule for formation of the committee, and with some important factors to be resolved, this model is best suited to address the concerns raised in the Auditor's report. The current plan is to bring this (and other fatality review teams) under the umbrella of OCME, which, as a neutral party dedicated to death investigations, is particularly qualified to coordinate the review processes. I am hopeful that the necessary resources will be allocated to effect this plan.

Thank you for affording me the opportunity to review and comment on this report.

Respectfully,

A handwritten signature in black ink, appearing to read "Jonathan L. Arden". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Jonathan L. Arden, M.D.
Chief Medical Examiner